MEDICAL CONCEPTS AND PENAL POLICY

a study of the use of 'medical' concepts in penal discourses

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This thesis has been composed by myself and is based upon my own research.

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ABSTRACT

This thesis examines the way medical concepts have been used in penal discourse, in Britain, since the middle of the nineteenth century. By doing this it tries to contribute to our knowledge and understanding of "medical" styles of penal control and to show, in particular, how these differ from classical or 'juridical' forms of penal intervention.

A methodological presupposition - which is substantiated throughout the thesis - is that it is necessary to analyse the meaning of medical concepts in penal discourse in their own terms. If we want to understand these concepts we have to look in detail at the way they are employed and elaborated in penal discourse. We cannot rely upon analogies with clinical medicine to determine their meaning. Apart from strictly methodological concerns, there are two substantive reasons for this: (a) medical concepts are employed within penal discourse as much for their rhetorical power and practical convenience, as for their explanatory utility; and (b) medical concepts are generally used in penal discourse to express a social-psychological - as opposed to an organicist - perception of criminals and their treatment.

The analysis of medical concepts in penal discourse is presented through two case studies. The first of these examines the way the terms "inebriety" and "alcoholism" have been used in discourses on "inebriate (or alcoholic) offenders", and also examines what is meant by the term "treatment" when it is used in the context of the treatment of inebriate offenders. The second study traces the various ways in which the terms "moral insanity", "moral imbecility" and "psychopathy" have been employed in penal discourses. One point which clearly emerges from these studies is that the use of medical concepts in penal discourse does not imply a clear break with traditional punitive responses to crime. Rather, punitive and medical conceptions of crime and treatment have been harmonized, to a considerable extent, to bring about more subtle changes in penal thought, policy, practice and institutions. The thesis concludes by looking at the implications of the study for our understanding and assessment of psychological theories of crime and therapeutic approaches to social control.

CONTENTS

CHAPTER 1

MEDICAL CONCEPTS AND PENAL POLICY

INTRODUCTION

Since the second half of the nineteenth century the term 'treatment' and other medical-sounding terms, such as 'inebriety' and 'psychopathy', have been used regularly in the discourses of penal policy in Britain. This thesis will examine what is meant by these terms when they are used in this context. It will therefore describe some of the policies, practices and institutions which are typically referred to as constituting 'penal treatment' and it will examine the way in which those who deal with offenders ascertain, describe and explain conditions, such as inebriety and psychopathy, which are often referred to as illnesses. On the basis of this investigation it will be argued that the term 'treatment', as used in the discourses of penal policy, generally refers to an activity which differs substantially - in terms of its objectives, methods and underlying logic - from a medical model of treatment. It will also be argued that those who deal with offenders tend to employ medical-sounding concepts in a manner quite different to the way illness categories are employed in a medical model of illness.

The main purpose of this exercise is to help us to understand the distinctive features and the social consequences of modern forms of penal control. Sociologists have regarded the increasing use of medical terminology in the discourses of penal policy as a sign of a more general transformation in the rationale and methods of social control in modern industrial societies, a transformation which is

generally summed up in terms such as 'the medicalization of deviance and social control' (Conrad 1981). Sociologists such as Conrad (ibid), Zola (1972) and Box (1980) and legal theorists such as Kittrie (1971) have argued that - contrary to the conventional wisdom which regards medicalization as a humanitarian and progressive development - the medicalization of social control has in fact been detrimental to human rights and progressive politics. In this thesis I will argue that while there has been a transformation, since the second half of the nineteenth century, in the rationale and methods of penal control, those sociologists who subscribe to 'the medicalization thesis' have mis-understood, in fundamental ways, the nature and consequences of this transformation. One of the main reasons for this mis-understanding, I will argue, is that these sociologists have mis-interpreted the way in which medical-sounding terms, such as 'treatment', are employed in the discourses of penal policy. They have tended, for instance, to presume that the term 'treatment' carries the same meaning when it is employed in the discourses of penal policy as it does when it is employed in the context of somatic medicine. This thesis sets out to demonstrate that this presumption is quite mistaken.

While intended primarily as a contribution to our understanding of modern forms of penal control, it is hoped that the thesis will also contribute to our understanding of social policy in general. The tendency towards the use of medical terminology in the discourses of penal policy was not an isolated development, rather it formed part of a more widespread tendency towards the use of medical terminology in

the discourses of social policy. For instance, the tendency to use the term 'treatment' in the context of penal policy coincided with a tendency to use the term in the fields of poor law administration (see Williams 1981: ch.3) and special education (see Nokes 1967: ch.6). Similarly, there has been a tendency to use medical terminology in the discussion of a wide range of social phenomena, such as sexuality (see Foucault 1979). Some sociologists have regarded this increasing use of medical terminology in non-medical contexts as forming part of a transformation in the way society is governed, a transformation which has been characterised, variously, as the 'medicalisation of life' (Lasch 1980), the 'triumph of the therapeutic' (Rieff 1966) and the rise of 'the therapeutic state' (Kittrie 1971; Lasch 1980). Once again writers such as Kittrie and Lasch are concerned to contest the conventional evaluation of this development, as progressive and humanitarian, and to reveal its more disturbing aspects.

I would agree with these writers that the use of medical terminology in discourses of social policy and social phenomena forms part of a transformation which has taken place, in Britain and other modern industrial societies, since the mid-nineteenth century, in the rationale and methods of social policy. However, if we are to understand the nature and consequences of this transformation it is necessary to understand how medical-sounding terminology is used in these other areas of social policy. Such an investigation might put in question the characterisation of this development as the 'medicalisation of life' or the 'rise of the therapeutic state' and might also put in question the negative evaluation of the development.

If the arguments of this thesis are correct then it might be asserted, with some justification, that the use of medical-sounding terminology in discussions of penal policy is inappropriate. It might be argued that, by using medical-sounding words, those who deal with offenders help to create a misleading image of the practices which they undertake, of the institutions in which they work, and of the knowledges which they employ. So why do those who deal with offenders use words which have overtones of medical practice? Why have they not tried to develop an alternative idiom, one which clearly conveys the differences between 'penal treatment' and medical treatment? What is the attraction of medical-sounding concepts? In order to answer these questions it is necessary to consider the prestige of modern medicine and the associated persuasive power of medical imagery.

The prestige of modern medicine derives, in large part, from the success it has had in combatting the problem of illness and disease. Medicine is a professionally organised social practice which not only aims to ameliorate human suffering but also, to a considerable extent, succeeds in achieving this objective. However, before the nineteenth century, medicine's capacity to undertake *effective* interventions into the problem of bodily illness was quite limited. The ability of medicine to provide effective remedies for ill health was greatly advanced in the nineteenth century by the application of the methods and logic of the natural sciences - and particulary the sciences of biology and chemistry - to the analysis of bodily processes and functions (Hirst and Woolley 1982: 100).[1]

In the second half of the nineteenth century the increasing capacity of medicine to understand and effectively intervene into the problem

of ill health inspired those concerned with other social problems, such as the problem of crime, to follow its example. It also inspired members of the medical profession to apply themselves to other social problems such as crime. By applying medical-scientific methods and reasoning to the analysis of criminality, penal reformers - many of whom were also medical professionals - hoped to obtain a level of success in controlling and eliminating crime similar to that which medicine had achieved in controlling and eliminating illness. For some this meant that penal policy had to be put, like medicine, on a scientific basis. The following, from an article titled '*Science Approaches the Lawbreaker*', published in 1928, typifies this view.

> . . . the methods employed by the Man of Science should be extended from the care and treatment of the body to the care and treatment of the soul . . . Science has already rescued the body of man from the unscientific hands of the medieval practitioner who, ignorant of the true causes of the maladies he has sought to cure, had recourse to remedies which we now see were not calculated to produce the desired results . . . All that now remains is to allow the Men of Science in a similar manner to rescue the soul of man out of the hands of the medieval psychologist - whose way of thinking underlies and is exemplified by our present penal methods. (Gardner 1928: 205)

We might interpret Gardner as arguing simply for the introduction of scientific rationality into penal practice. Gardner uses the progress of medicine as a model, an example of what can be achieved when scientific rationality is applied to human problems. But in the second half of the nineteenth century, the idea of modelling penal practice upon medicine was often taken much further than this. For some 'criminologists' it was not simply scientific reasoning, but biological science itself, which was to be applied to the analysis of criminality. Just as doctors had successfully utilised biological science in analysing and treating bodily illness, many criminologists

attempted to analyse criminality and to deal with it as a physiological abnormality; criminality was reduced to biological processes.[2] Medical terminology was therefore adopted in discussions of criminality and penal policy as part of an actual attempt to apply medical methods and reasoning to the problem of crime. There appears to have been a real hope that, by adopting a medical approach, the causes of criminality could be better understood and the problem of crime better controlled.

There was however an additional advantage to be obtained from the utilisation of medical concepts. By framing its theories and propositions in medical-scientific terms, the new 'natural science criminology' could utilise the scientific status, social prestige and caring image of medicine in order to promote its radical theories and penal programme. Because of the social standing and scientific reputation of medicine, penal reform proposals were likely to meet with greater success if they were expressed in the idiom of medical science.

Even so, this natural science criminology - despite gaining considerable popular appeal - failed to make a deep impact upon the thinking of penal officials and correspondingly failed to translate its programme of penal reform into official policy.[3] However, at roughly the same time as this natural science criminology appeared, there also emerged another form of criminology, one which differed substantially - in terms of its theories of criminality and in terms of its penal reform programme - from natural science criminology. This other criminology was much more subtle, moderate and compromising than natural science criminology and, largely because of this, it had a far

greater impact upon official penal policy. One of the key distinctinctive features of this more moderate criminology was that it analysed criminality, not so much as a biologically-based condition, but as a socio-psychological abnormality. The terminology of physiological medicine was therefore somewhat inconsistent with the propositions of this 'social psychiatric criminology'.

Nevertheless this new social psychiatric criminology continued to utilise medical terminology; it employed medical terminology *metaphorically* in describing and explaining its concepts, theories and penal reform proposals. One of the main reasons for this, I would suggest, is that the proponents of social psychiatric criminology found the medical metaphor tactically useful in promoting their theories and policy proposals. Although medical terminology was somewhat inconsistent with the actual propositions of social psychiatric criminology, it was nevertheless useful to employ such terminology because of its persuasive power (cf. Garland 1985: ch.6). Through the use of medical metaphor, the proponents the new social psychiatric criminology could draw upon the respectability of medical interventions. I would suggest therefore that medical terminology was retained partly because it allowed the proponents of socio-psychological criminology to utilise the scientific prestige and social standing of somatic medicine in promoting their own, not specifically medical, programme.

This is not to suggest that medical terminology was employed as part of some cynical public relations exercise. It should be stressed that many of those involved in penal reform have been medically qualified professionals. The increasing use of medical terminology in penal

policy discussions is also part of a broader development whereby the prestige of medicine has been such that members of the medical profession have been seen as competent in fields far removed from their immediate area of expertise. It is also likely that those who employed medical terminology were themselves attracted by the idea that what they were doing, within the field of penal practices, was analogous to what doctors were doing in the field of somatic medicine. The use of medical terminology in discussions of penal policy is a reflection of the social and professional aspirations of those who deal with offenders. As Peter Nokes (1967) has argued, the treatment role is a highly sought after one in 'the welfare professions' because of the prestige which it bestows upon those who occupy it.

This helps to explain how medical-sounding concepts came to be employed in discussions of penal policy and why such terminology was still used long after it had become, strictly speaking, inappropriate in terms of the actual propositions and policies being discussed. However, it is still necessary, if we are to understand modern forms of penal control, to examine what is meant by medical-sounding terms when they are used within the context of penal policy. This is the task which I will address in this thesis.

I will start, in this chapter, by discussing the *critics* of medicalization - since it is they who have analysed this phenomenon most explicitly and, in my view, have most clearly misunderstood its meaning - looking in particular at the way these critics have conceptualized and evaluated the transformations which have taken place in the rationale and methods of social control since the second

half of the nineteenth century. In the rest of the thesis I will present two case studies: the first will examine penal discourse regarding the 'treatment' of inebriates and alcoholic offenders since the second half of the nineteenth century; the second examines penal discourse with regard to the problem of moral insanity and psychopathy since the 1830s. In each of these studies it will be possible to examine the emergence and development of medical-sounding terminology and to assess the way in which such terminology is used. It will also be possible to look at the way in which the emergence of such terminology relates to changes in the rationale and methods of penal control. On the basis of these studies I will argue that the 'medicalisation thesis' misunderstands the way terms such as 'treatment' are used in discussions of penal policy and hence misunderstands the nature and the consequences of the changes which have taken place in the rationale and methods of penal control since the mid-nineteenth century.

THE JURIDICAL APPROACH TO SOCIAL CONTROL

As I have indicated, a major argument of my thesis is that many of the criticisms which have been made of 'the medicalization of social control' are based upon a mistaken and inadequate understanding of the changes which have taken place in the rationale and methods of social control since the second half of the nineteenth century. Proponents of the 'medicalization thesis' have conceptualized this change as being away from a juridical (or legal) approach to social control and towards a therapeutic (or medical) approach (e.g. Zola 1972). In order to assess the accuracy and adequacy of this assumption, it is

necessary to look in detail at what is meant by a 'juridical approach to social control' and a 'therapeutic approach to social control' respectively. I will start by constructing an ideal type of 'the juridical approach to social control, trying to identify its central, distinctive features.

Ideological basis

The juridical approach to social control is based within - and indeed forms an important constitutive part of - a wider ideology of liberalism. The overriding objective of liberalism is to secure a political system in which the *freedom* of individuals is maximised. Freedom, in liberal theory, is conceived in 'negative' terms as the absence of constraint or compulsion (see Young 1980: 122). So, according to liberal ideology, people should be "entitled to do what they want as long as they do not transgress the rules which have been set up beforehand by themselves or their representatives and which are there to prevent destructive clashes of interests" (Bankowski 1989: 2).

Social control is therefore highly problematic within liberal ideology. Social control constrains and compels; it interferes with the individual's *right* to do what he wants. Penal methods of social control, such as imprisonment, are particularly problematic, since imprisonment constrains and compels almost absolutely. Imprisonment appears to be almost the ultimate negation of freedom.

We might ask then how social control, and particularly penal forms of social control, are justified within liberal ideology. The answer can be found in the above quotation from Bankowski's characterisation

of 'democratic liberty'. A limited amount of social control is regarded as necessary in order to prevent "destructive clashes of interest". If everybody does what they want, then some people will inevitably interfere with the freedom of others. The objective of maximising the freedom of each individual would thereby be frustrated. It is therefore necessary that individuals obey a set of rules designed to prevent individuals interfering with the rights of others. It is true that in being compelled to obey these rules the freedom of individuals is restricted to a certain degree, but this is necessary in order to prevent some individuals from making even greater encroachments upon the freedom of others. Each individual must surrender a small portion of his freedom, in exchange for the protection of his remaining freedom.

The form and objectives of juridical social control

This liberal conception of the relationship between freedom and social control dictates a particular form of social control. Social control is to be achieved through the instrument of law. A set of rules, specifying conduct which is prohibited, is declared. Steps are then taken to ensure that individuals do not transgress these rules. Liberalism therefore favours a *prohibitory* form of social control. The objective is to induce people to conduct themselves within certain limits. As long as their behaviour remains within the limits imposed by law, people should be subject to no other form of constraint or compulsion. The purpose of social control is to prevent people from breaking the law and thereby harming others; it is not the business of

social control to compel people to adopt better ways of behaving. As the nineteenth century liberal theorist J. S. Mill put it:

> . . . the only purpose for which power can rightly be exercised over any member of a civilised community against his will is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant" (Mill, quoted in Greenwood and Young 1980)

Methods of social control: (a) deterrence

Making rules is one thing, getting people to obey them is an entirely different matter. I will now go on to look at the liberalism's preferred methods of inducing conformity to the law.

The main 'technique' of social control suggested by liberalism is the use of *deterrent punishment*.[4] Liberal penal theorists, such as Bentham, Beccaria and Feuerbach, argued that the punishment of those who transgressed the criminal law would prevent the commission of further offences - either by the offender *or by others tempted to commit crime* - since people would try to avoid having similar punishments inflicted upon themselves.[5] In other words, social control was to be achieved by making an example of the convicted offender. However, for liberal penal theorists the practice of punishment had to conform to certain conditions if it was to function as an effective deterrent. Before outlining these conditions it is necessary to look closer at the concept of deterrent punishment.

An essential ingredient of punishment is that "it involves a deliberate and avoidable infliction of suffering" upon the offender (cf. Honderich 1976: 11). In liberal penal theory this ingredient was refined so that punishment was conceived, not so much the direct infliction of corporal suffering, but as the deprivation of a good, or

the removal of something desired (ibid). Within liberalism, the most symbolic punishment is imprisonment, the deprivation of liberty. The offender, who has broken the rules which are there to protect the freedom of others, has his own right to freedom suspended. Other punishments favoured in liberal societies, such as the monetary fine, also involve depriving the offender of something which liberal ideology regards as highly valuable. Essentially, then, punishment is something which is calculated to *harm* the offender. It is something which is intended to cause the offender *pain*.

When considering deterrence it is useful to bear in mind another ingredient of punishment, its stigmatizing affect. Although this is not always the result of a deliberate policy, punishment generally causes *disgrace, humiliation and shame*. So, in being punished the offender is made to suffer in a two ways; first, the rights which he would normally enjoy as a citizen are suspended; and secondly, he incurs the pain of injured reputation, property, or person.

Liberal penal theorists assumed that since punishment is something painful and disgraceful, individuals would try to avoid it. This assumption rests upon a definite perception of the criminal actor. This perception consisted of two interrelated elements: *free will and rationality*.

Free will: The idea of deterrent punishment assumes that people, including criminals, are self-governing individuals, with the capacity to direct and control their own behaviour through an act of will. This conception of human action provides a moral justification for punishment, since it allows criminal actions to be construed as the

product of a conscious choice to commit crime; hence the criminal can be held to be morally *responsible* for his offence and thus deserving of punishment. What is important here though is that the idea of deterrent punishment, likewise, presupposes crime to be a 'wilful' act. Deterrence presumes that persons have the ability to choose whether to act in a lawful or unlawful manner. This can be seen most clearly when it is stated the other way round: if a person was not capable of acting in accordance with free will, if his actions were determined by forces beyond his control, then that person would commit a crime, if he were destined to do so, regardless of what the consequences might be.

Rationality: The concept of deterrent punishment also presupposes that people will act in a manner calculated to be advantageous to themselves. People will follow (what they calculate to be) the most profitable course of action. They will always do what they think it is in their best interest to do. It is important to point out, however, that deterrence does not necessarily presume that this process of calculation is a conscious one. Hence to state this presumption in the vocabulary of the utilitarian 'psychology' from which it was derived: all persons follow a course of action calculated - albeit unknowingly - to maximize their pleasure and to minimize their pain. Or, to quote Bentham:

> Each individual conducts himself, albeit unknowingly, according to a well or ill-made calculus of pleasures and pains. Should he foresee that a pain will be the consequence of an act which pleases him, this idea will act with a certain force so as to divert him from that action. If the total value of pain appears greater to him than the total value of the pleasure, the repulsive force will be greater; the act will not occur. (Bentham, quoted in Pasquino 1980)

Hence should a person foresee that punishment (which, as we have seen, is essentially something painful) will be the consequence of a criminal action (which might in itself bring profit or pleasure) then that person will be diverted from the criminal act, provided that the threatened punishment is severe enough to outweigh the pleasure to be gained from committing the offence. So, it is presumed to be possible to prevent crime by impressing upon citizens the realization that the commission of a crime will be followed by the imposition of a punishment which would more than offset the advantage to be gained from the crime.

In the above quotation from Bentham there are two crucial points: first, the person must *foresee* that punishment will be the consequence of a crime; secondly, the punishment must be sufficient to *outweigh* the profit of the offence. These two factors impose certain conditions upon the practice of punishment, which must be adhered to if punishment is to function as an effective deterrent.

Publicity: If people are to foresee that crime will be followed by punishment, then it is necessary to 'advertise' the fact. What has to be maximized, therefore, is not so much the penalty itself, but its representation (Foucault 1977b: 94-5). This point has been well illustrated by Pasquino, who cites the following two remarks from Bentham. I have repeated then here since, as Pasquino states, they throw light upon the 'punitive rationality' of liberal theory.

> (a) "If an abridged edition of the penal code were to be published, illustrated with woodcuts showing the specific penalty laid down for each kind of crime, this would act as an imposing commentary, a sensible image of the law. Each person would then be led to think to himself: this is what I must suffer if I should break the law."
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> (b) "The penal scene is located in the neighbourhood of a

> metropolis, the place which contains assembled the greatest number of men and of those among them who most need to have displayed before their eyes the punishment of crime. The appearance of the building, the singularity of its form, the walls and moats that surround it, the guards at its gates, all this serves to reinforce the idea of malefactors confined and punished: the ease of admission could not fail to attract a great number of visitors . . . What a most striking spectacle for the most numerous class of spectators! What a theme for conversations, allusions, domestic lessons, useful stories! . . . And yet the real penalty is less great than the apparent one . . . The punishments being visible, the imagination exaggerates them." (Bentham, quoted in Pasquino 1980: 21-2)

Certainty: If people think that they can escape the punishment, some will yield to the temptation to commit crime. Liberal penal theorists therefore emphasized certainty of conviction and punishment as the best means of achieving deterrence. If punishment was to operate as an efficient deterrent it was essential to impress upon individuals that every crime would be punished. This ideal of certainty of conviction and punishment led to a number of specific penal policies. It led, for instance, to support for the establishment of an efficient, rationally organised police force (Foucault 1977b: 96; Reiner 1985: 11). For the purpose of this study, however, the ideal of certainty has had two important sets of consequences for penal policy.

First it has led to, what might be termed, a 'positivist' approach to criminal law. Liberal penal theorists favour a definite, publicly declared, set of criminal laws; i.e. a penal code which is known to all (cf. Foucault 1977b: 95-6). A crime then consists simply of an infraction defined by law (cf. Pasquino 1980: 19). Conduct which does not infringe a specified law does not constitute a crime, no matter how unjust or reprehensible it is judged to be, and regardless of whether it transgresses traditional or customary rules. Liberalism is therefore against the notion of 'natural crime'. For the purpose of

deterrence the advantage of this stance is that it enables people to clearly distinguish between criminal actions and lawful actions (cf. Foucault 1977b: 95-6). The link between crime and punishment therefore becomes more 'obvious'; punishment can be seen as the inevitable response to a transgression.

Secondly, the need for certainty has led to a dislike of *discretion* in the system of penal control. In order to deter crime it is necessary to impress upon citizens that if they commit a crime they will automatically suffer the prescribed punishment for their offence (ibid). In order to do this it is necessary to ensure that those who are convicted of offences do, in fact, have the prescribed punishment imposed upon them. For this to be possible a number of conditions have to apply. For instance, as Foucault points out, there can be no right to pardon (ibid). What is most important for this study, however, is that there has to be a system of determinate sentencing. If penal officials, or anybody else, are allowed to waive or even substantially adjust the penalty, the possibility of escaping the prescribed punishment for an offence might again enter the minds of those tempted to commit crime. The prescribed penalty for an offence should be stated in advance, and then applied with as little variation as possible.

Proportionality: In order to deter crime the punishment has to be sufficiently severe to offset any advantage or 'pleasure' which the offender might derive from his crime. In the words of Bentham, punishment should be "not less in any case than is sufficient to outweigh . . . the profit of the offence" (quoted in Kittrie 1971). However, any punishment in excess of that necessary to offset the

profit of the offence would be - for liberalism - an unnecessary infliction of harm. Punishment should therefore be proportionate *to the offence* committed. The amount of harm inflicted upon the offender should be roughly equal (or rather slightly greater than) the amount of harm caused by the offence.[6]

Methods of social control: (b) reformation

A second 'technique' of social control, which some liberal theorists advocated, was the reformation of offenders. In the case of reformation, punishment is used as a device, or as an opportunity, for improving the offender's character and habits, thereby making it less likely that he will offend again in the future.

It is necessary to distinguish two different concepts of reformative punishment. In the first it is suggested that punishment itself can be used to bring about a change in the offender's 'character', and may even strengthen the resolve of others not to commit crime. In the second, it is suggested that punishment should be *accompanied* by the use of reformative techniques; punishment being used as a means of compelling the offender to submit to these techniques (see Bean 1981: 46). The first of these concepts of reformative punishment has been explained by Hart, who also, conveniently, distinguishes this idea of reformation from that of deterrence:

> It is possible that the actual experience of the pains of punishment may lead to what is usually meant by 'reform', viz. a change of heart and effective resolution to conform to law not because of fear of repeated punishment but out of moral conviction. . . . Others have argued that the application of punishment to an actual offender, by marking the law's condemnation of a crime, may not merely deter potential offenders through fear but may strengthen their moral inhibition against the conduct thus condemned, and this too, may be considered a species of reform. (Hart 1968: 240)

What is distinctive about this idea of reformation is that it does not require the use of any special reformative techniques. Punishment itself is the means of bringing about a change in the offender's moral disposition. However, in the second concept of reformative punishment, it is suggested that reformative 'techniques' should be employed *in addition to punishment* in order to bring about an improvement in the offenders character and habits. So, if we are to explain the nature and consequences of the changes which have taken place in the rationale and methods of social control since the second half of the nineteenth century, we need to ask what were the *preferred* methods of reforming offenders. Without going into too much detail, we might identify the favoured reformative techniques as being *discipline, education and moral exhortation.* These techniques, we might note, had one thing in common, they were all best developed in prisons (see Salmond 1920: 76). In the second half of the nineteeth century incarceration was a favoured form of punishment partly because of its usefulness for reformative purposes. I will now look, very briefly, at each of these 'techniques'.

Discipline: In the second half of the nineteenth century, prisoners were subjected to a regime of uniform discipline, which included features such as a strict timetable, regulation diet, hard labour and punishment (such as reduction of diet, increased work periods and corporal punishment) for deviation from the rules (Garland 1985: 12-13; cf. Foucault 1977b). One of the functions of discipline was to train the offender in regular and productive habits, thereby contributing to his reform (cf. Foucault 1977b).

Education: Some prisoners in the second half of the nineteenth century received a small amount of elementary education (Garland 1985: 13). As with elementary education in general, part of the purpose of this was to enable the recipient's moral improvement.[7]

Moral exhortation: As well as receiving elementary education, prisoners might also be subject a small amount of more direct moral exhortation, by the chaplain or a philanthropic visitor (cf. ibid).

This second concept of of reformative punishment was not acceptable to all liberal penal theorists. As we have seen the idea of making people behave well, through the use of compulsion and constraint, was somewhat at odds with the liberal ideology of 'negative freedom'. Reformative punishment, which attempted to improve the offender's moral disposition and habits under conditions of compulsion, could easily be regarded as a breach of the person's *right* to one's own morality, a right which extended even to criminals, who could not be forced to conform to the law, but could only be punished for their transgressions. Hence for Beccaria:

> Reformation is not to be thrust even on the criminal; and while, for the very fact of its being enforced, it loses its usefulness and efficiency, such enforcement is contrary to the rights of the criminal, who can never be compelled to anything save suffering the legal punishment. (Beccaria, quoted in Garland 1985: 34)

However, other liberal penal theorists were less hostile to the concept of reformative punishment and Bentham actually promoted the idea (Garland 1985: 16-17; Rodman 1968). In Britain, as Garland points out, official penal policy was closer to Bentham than to Beccaria; reformation was regarded as a subsidiary objective of punishment (Garland: ibid). It needs to be stressed, however, that in the second

half of the nineteenth century reformation was only a subsidiary objective of British penal policy. The idea of reformation had most impact upon the working of quasi-penal institutions, such as reformatory and industrial schools for young offenders (ibid: 8). In the prisons, which lay at the centre of the penal system, the objective of reformation was regarded as subordinate to other objectives, such as deterrence, less-eligibility and uniformity (ibid).

THE THERAPEUTIC APPROACH TO SOCIAL CONTROL

Having briefly described some of the central distinctive features of the juridical approach to social control, I will now move on to construct an ideal type of 'the therapeutic approach to social control', the approach to social control which, according to the medicalization thesis, is replacing the juridical approach in modern societies such as Britain.[8]

Ideological basis

While the juridical approach to social control is based within the ideology of liberalism, the therapeutic approach to social control is based within an ideology of welfare. Hence Kittrie (1971), examines the shift towards a therapeutic approach to social control within the context of a broader transition towards a welfare/therapeutic state. As with the liberal state, the objective of the welfare state is to promote the freedom of individuals. However, in the ideology of welfare, freedom is conceived in a *positive* sense. Freedom is no longer regarded as the absence of constraint and compulsion, rather it is seen as requiring that the individual's basic needs are met. Where

these needs cannot be met by the individual's efforts in the open market, it becomes the duty of the state to meet them. In the ideology of welfare, freedom therefore requires positive intervention by the state. Accordingly, the welfare state is a paternalist, interventionist state; one of its major functions is to ensure that its people are provided for and cared for.

Within the ideology of welfare, social control is not as problematic as it is within the ideology of liberalism. Constraint and compulsion are not necessarily the negation of freedom, since freedom is something more than - and other than - the entitlement to do what one wants. There is not the same concern, within welfarism, to restrict social control. Indeed such restriction may be regarded as harmful where social control is considered necessary in order to promote the welfare of the individual.

This brings us to a crucial feature of welfarism. Within the ideology of welfarism social control is often justified, not simply as a necessary evil - i.e. necessary in order to prevent destructive clashes of interest - but as a useful instrument in promoting the welfare of individuals. By constraining and compelling individuals, the state can act for the ultimate benefit of those individuals. Social control is regarded as being, in many cases, freedom-enhancing rather than freedom-restricting.

The form and objectives of therapeutic social control

This transformation from liberalism to welfarism entails an accompanying shift in the form and objectives of social control. In welfarism, the objective of social control is not simply to ensure

that persons remain within the law, rather it is to enhance the welfare of the individual. This leads to a shift away from breaches of the criminal law as the sole justification for the initiation of social control. If the purpose of social control is to produce 'well' individuals, then any conduct which interferes with the well-being of individuals should be restrained through social control measures. The ambit of social control is therefore greatly expanded. Social control under welfarism is concerned not only with those who break the law, but with others whose habits and characteristics are detrimental to their well-being.

Methods of social control: treatment

From what has been said, it might be seen that the ideology of welfarism encourages a great deal more of social control than does liberalism. This has implications for the study of social control, since studies must now take into account a far wider and more diversified range of activities.[9] The social control which takes place within the criminal justice system is only one part, albeit a very important part, of the welfare State's official social control apparatus. For the purposes of this thesis, however, I will concentrate upon social control within, and at the boundaries of, the criminal justice system. I will use the term penal control to distinguish this aspect of social control from social control in general.

The question then is what is welfarism's preferred mode of inducing compliance with the law. Proponents of the medicalization thesis suggest that with the shift towards welfarism there is a double shift

in the preferred mode of penal control. First, reform replaces deterrence as the primary method of penal control (see Allen 1973). Secondly, there is a change in reformative techniques, away from moral persuasion and towards medical-scientific techniques of reform (ibid). It is this last claim that gives the medicalization thesis its distinctive flavour - and it is this claim which I will be particularly concerned to challenge in this study.

From deterrence to reform

First, I will look at the suggestion that reform is replacing deterrence as the primary method of penal control. This, in itself, would have a number of important implications for penal control. In particular, it would lead to an erosion of the principle of determinate sentencing (see Bean 1981: 64). If reform is the primary objective of penal control then there is little point in releasing an offender from the ambit of penal control until he has been reformed. In a purely reformative system the offender would be subject to penal control until his character and habits had been improved to the extent that he was unlikely to commit further offences or other delinquencies. Similarly, there would be little point in subjecting a reformed offender to further penal control. Once the offender's character and habits had been improved, and he was no longer a nuisance or a danger, to others or himself, then - from the point of view of reform - there is nothing further to be achieved by subjecting him to further penal control.

Since it is difficult to tell in advance how long an offender would have to be subject to penal control techniques in order to be

reformed, it is necessary to modify, if not to abandon altogether, the principle of determinate sentencing. 'Sentences' cannot be strictly determined in advance, rather the length of 'reformative treatment' required must be left open to some extent. This has the further implication that the length of 'treatment' is to be decided, not solely in advance by a judge or jury, but on a more or less day to day basis by those responsible for administering reformative treatment. Decisions about penal control pass, to some extent, from the law to penal officials, the administrators of penal treatment.

The shift in language here - from the punitive term 'sentencing' to the medical-sounding term 'treatment' - is important. With the shift towards reform, the criteria used to determine the length of penal control become more like those used in medical treatment. Take, for example, the way decisions are made governing the length of stay in a hospital. The expected length of stay may be determined in advance, although in difficult cases it might be 'left open'. Even where the decision is made in advance, however, the length of stay may be modified depending upon the outcome of treatment. If the treatment is particularly successful, the patient may be released early; if there are any complications, the patient may be detained longer. In any case, the patient shouldn't be released until he is well enough to return home. The ultimate decision will be made by those responsible for the patient's treatment, and it will be made 'after the event'. The medicalization thesis suggests that with the shift towards a primarily reformative approach to penal control, this medical logic is applied to decisions about the length of time an offender needs to be subjected to penal control (see Bean 1981: 64).

If a shift towards reformation implies an erosion of the principle of determinate sentencing, then the principle of proportionality must also be modified, if not abandoned. The length of period an offender is subject to penal control would have to be governed, not by the seriousness or profitability of the offence, but by the offender's character and habits. The measure of the length of treatment is the offender's character, rather than his offence.

From moral persuasion to treatment

I will now move on to outline the claim that traditional techniques of reformation are being replaced by medical-scientific techniques. According to this claim, attempts to reform the offender through punishment and moral persuasion have given way to the medical-scientific control of human behaviour. This transformation itself depends upon a shift in the way human action in general, and criminal action in particular, is understood. Criminal acts are no longer regarded as freely chosen, rationally calculated actions, but are seen as the determined outcome of antecedent causes. As Allen (1973) put it:

> It is assumed, first, that human behaviour is the product of antecedent causes. These causes can be identified as part of the physical universe, and it is the obligation of the scientist to discover and to describe them with all possible exactitude. Knowledge of the antecedents of human behaviour makes possible an approach to the scientific control of human behaviour. (Allen 1973: 173)

The therapeutic approach to crime is based, then, upon a medical-scientific model of criminality (see e.g. Balch 1975; Box 1980; Moran 1980). This views crime not as a voluntary, calculated act, but as an 'illness', as the determined product of underlying physical or

psychological attributes.[10] It is this medical-determinist mode of explanation which makes the project of medical-scientific penal control possible. If criminal conduct has definite causes, and if those causes can be identified and the process by which they lead to criminal behaviour can be understood, then it is possible to prevent further offences. Crime can be prevented by removing the cause, or by diverting the process by which it leads to criminal conduct. It is also possible to prevent crime more generally, by identifying those likely to commit criminal acts in the future before they have actually comitted an offence. This can be done by examining people in order see whether they display the symptoms of 'criminality' or else possess the physical or psychological attributes which lead to crime. The therapeutic approach to crime involves, then, not only the treatment of offenders, but also a wider social programme geared towards the identification of future offenders and treating them in order to prevent them from actually becoming offenders (see Clarke 1975: 36; Kittrie 1971: 30-31).

What then are the techniques used to control the behaviour of offenders and of others with a propensity to crime, and in what sense are they different from traditional reformative techniques?

Some proponents of the medicalization thesis have tended to focus upon the emergence of somatic treatments. Conrad (1981), for instance, presents a list of examples of medical solutions which have been developed for behavioural problems and social deviance. All of the treatments that he mentions involve physical treatment of some sort. Hence, he points to the development of drug treatment for

exhibitionists and hyperactive children, psychosurgery for young men prone to violent outbursts, medication given to to alleviate 'mood disorders' of prisoners, by-pass operations for obesity and heroin-blocking agents for drug addicts. In a similar vein, Moran (1980) - in a paper dealing specifically with the 'medical control of criminality' - points to the use, in the United States, of psychosurgery on those involved in urban riots. This literature pays little attention to the specific objectives or operational principles of these treatments, but it is generally presumed that their objective is to prevent delinquency by subduing the delinquent (Conrad 1975; Box 1980). Most importantly, however, is the assumption that *these treatments actually work*. The use of physical treatment is regarded as successful in preventing individuals from behaving in a criminal or delinquent manner (Box 1980). For instance, in a paper on the drug treatment of 'hyperkinesis', a behavioural disorder in children, Conrad (1975: 17) states that drug therapies have actually been successful in their objective of making children less disruptive and in enabling them to learn.

More generally, though, proponents of the medicalization thesis also include, within the ambit of medicalization, the emergence of 'psychological' techniques of social control. Hence, Greenwood and Young (1980: 150), in discussing the "increasing use of scientific techniques in the deployment of reaction to deviance", include under this heading "the whole gamut of therapeutic approaches to the 'cure' of deviancy, ranging from drug therapy, through psychotherapy, to the use of therapeutic communities". Box (1980), discusses the use of brain surgery (which is very rarely used), drug therapies (which are

most popular) and also individual psychotherapy, behavioural therapy and methods of 'altering environmental contingencies'. Moran (1980) discusses psychological techniques of 'behavioural modification'.

Once again, though, proponents of the medicalization thesis do not tend to explain the specific objectives or operational principles of these various psychological techniques. It is assumed, however, that the objective is to produce conformity to law and other norms through the use of a variety of psychological techniques designed to alter the attitudes and habits of offenders and other delinquents. Once again, it seems to be assumed that these techniques are actually successful in producing conformity. It is presumed that the control of human behaviour through psychological techniques has actually been realised.

What distinguished these techniques, whether physical or psychological, from traditional reformative techniques is their effectiveness and intrusiveness. With traditional reformative techniques, such as moral persuasion, there was no guarantee of success; the offender could, if he so wished, resist all moral exhortation. Modern methods of treatment on the other hand, whether physical or psychological, are presumed to be capable of modifying the conduct and character of offenders, *whether or not the offender wishes to change*. They are capable of altering the conduct of "unwilling and unco-operative clients" (cf. Kittrie 1971: 10).

THE CRITIQUE OF THE THERAPEUTIC APPROACH

I will now move on to consider some of the main criticisms which sociologists and legal theorists have made of the therapeutic approach to social control. In doing this I will also try to show that these

criticisms are, in fact, aimed at the image of the therapeutic approach which I have just outlined (and usually entail a preference for the juridical approach which I have also described).

The benevolent image of social control and the erosion of procedural safeguards

As we have seen, the transformation from liberalism to welfarism entails a change in the way social control is viewed. From being perceived as a freedom-restricting punishment, social control comes to be regarded as freedom-enhancing treatment. One consequence of this is that welfarism places less emphasis than does liberalism upon the need for checks upon the exercise of social control. Where social control is justified as treatment, the need for procedural safeguards becomes less apparent. To quote Box (1980): "benevolent medical motivation dispenses of the need for due process". Or, as Balch (1975) put it: the medical/benevolence model legitimises a departure form due process, leaving ofenders subject to the discretion of medical experts.

This aspect of the therapeutic approach to social control has been criticised by legal theorists such as Allen (1973) and Kittrie (1971). They argue that the transformation to a therapeutic approach to social control has been accompanied by an erosion of civil liberties. Arguing from well within liberal ideology, they claim that even where social control is justified as being for the benefit of its recipient, it is still social control and therefore freedom restricting. Therapeutic social control therfore needs to be subjected to the same safeguards as more obviously punitive forms of social control. To quote Allen:

Measures which subject individuals to the substantial and

> involuntary deprivation of their liberty are essentially punitive in character, and this reality is not altered by the facts that the motivations that prompt incarceration are to provide therapy or otherwise contribute to the person's well-being or reform. As such, these measures must be clearly scrutinised to ensure that power is being applied consistently with those values of the community that justify interferences with liberty for only the most clear and compelling reasons. (Allen 1973: 181)

The expansion of social control and the threat to pluralism

As we have seen, the medicalization thesis argues that welfarism encourages more social control. Social control is no longer concerned solely, as it is in liberalism, with the prohibition of deviant conduct which is harmful to others, it is also concerned with conduct considered harmful to the deviant himself. Any habits or characteristics which are regarded as detrimental to the person's welfare are seen as a target for social control. Hence it has been suggested that the move towards a therapeutic approach to social control constitutes a threat to pluralism. Or, in the words of Kittrie (1971), it constitutes a threat to 'the right to be different'. This aspect of the therapeutic approach to social control has been criticized by the sociologist Zola (1972), who argues that the real danger from medical social control lies not in its being an overt evil, but in its benevolence. In its bid to create a perfect human society, the therapeutic approach to social control threatens civil liberties and the diversity which contributes to the quality of life.

Criticisms of the indeterminate sentence

The idea of indeterminate sentencing has been criticised on the grounds that it leads to a situation in which those who have no desire

to change their behaviour are subjected to long periods of incarceration, which is not justified by any offence they have committed (see Bean 1976: ch.1; Allen 1973). Many offenders, for a variety of reasons, do not want to be reformed. This is particularly true of those whose offences are politically motivated, or of those who have a 'principled' commitment to non-conformist behaviour. Under the indeterminate sentence system, these will be incarcerated for long periods, and subjected to reformative techniques. Even where these reformative techniques are unsuccessful, the offender will be subjected to "prolonged and degrading torment" (Rodman 1968: 210).''

The critique of medical-scientific techniques of social control

As we have just seen, attempts to reform offenders, even when they are unsuccesful, are considered to be problematic. The move towards effective, medical-scientific techniques of reformation, however, is regarded as constituting an even greater threat to the offender. As Rodman (1968: 210) puts it: to the extent that reformative techniques are based upon an adequate understanding of human psychology, and are therefore successful, they will "result in the coercion and manipulation of the individual to a degree not even imaginable under older, rougher methods".

The objection to medical-scientific techniques of social control forms the hub to the critique of the therapeutic approach to social control. The problem with such medical-scientific techniques is that they present the greatest threat of all to 'the right to be different'. Through the use of such techniques, offenders are not only punished for non-conformity, they are also transformed, against their

will, into conforming citizens. The whole process smacks of thought control, 'brainwashing' and totalitarianism - of *1984*, *Clockwork Orange and Brave New World* (see Cohen 1979).

The 'neutralization' of political dissent

This brings us to an important point. It might be noticed by now that the critics of the therapeutic aproach to crime are concerned not just with the the penal consequences of the therapeutic approach to crime - i,.e. with its consequences for offenders - but also (and perhaps mainly) with its political consequences. In order to explain this it is necessary to point out that much of the critique of the therapeutic approach to crime presupposes that crime (or at least a significant amount of crime) can be viewed as a form of political dissent. The commission of crime may be a principled breach of the law.[12] Alternatively, crime may be committed during a political protest. However, as we shall see in a moment, crime itself may be seen as an inherently political act. First though, I will consider a statement by Clarke (1975), who draws the link between crime and politics in relatively restricted manner. Clarke was concerned with those who "break the law on principle". With regard to such offenders, he writes:

> The dangers of treatment as indoctrination . . . become apparent. It is one thing to induce conformity by external sanctions, for this leaves it open to the individual whether to conform from expediency or to offend and incur sanctions. Treatment, however, is directed precisely at getting him to change his views about conformity rather than allowing him to keep the law despite his beliefs and campaign to change it. In starting out by helping offenders who may be constrained to recidivate, the treatment view may catch those recidivists whose transgressions are acts of protest at what they regard as evil laws. *In eliminating the propensity to offend, treatment may also eliminate the capacity to participate as a*

citizen in the political process of law-making . . .
(Clarke 1975: 35-6, emphasis added)

Clarke's concern is with the conscientious political offender. His objections to treatment do not appear to extend to the treatment of ordinary offenders. Others, however, have adopted a more radical attitude. Box (1980), for instance, suggests that most (if not all) delinquency is a form of political protest, even where it is not directly political.[13] Box's arguments were made in the context of the treatment of 'maladjusted' children, but they are clearly intended as being relevant to the understanding of all forms of delinquency, including crime; the medicalization of naughty schoolchildren "is merely an illustration of a much wider process of medicalizing social, moral and legal problems" (ibid).

Box argues that 'naughty behaviour' of schoolchildren is often an inarticulate protest, a "gesture of moral outrage" at the injustice in society and in schools (injustice which is ultimately the product of capitalism, which educates youths for jobs which don't exist). Naughty behaviour, therefore, if it was interpreted properly and listened to, could become a focal point for political change. Instead, however, this protest is silenced by the medical profession who define naughty children as 'hyperactive' or 'maladjusted' and then 'treat' them with drugs. This treatment has the effect of turning naughty children into obedient, orderly children who are prepared to submit to the schools authority. As Lasch (1980) put it, the new mechanisms of therapeutic control pacify "a formerly rebellious population". Treatment quietens the population, making it more manageable" (Greenwood and Young 1980: 159) Social harmony, civil tranquillity and school discipline are

produced, but in a 'criminogenic society' social harmony is undesirable - what is required is revolt. So, for Box, the role of treatment is to ensure that revolt doesn't take place; treatment is therefore regarded as a means of protecting the existing, unjust, social order:

> A generation of urban poor, many of them on prescribed drugs since their infancy, are hardly going to transcend their medication and revolt. Instead they are likely to have internalised the medical view that they are indeed sick cases and merely seek medical or quasi-medical treatment. (Box 1980)

The de-politicization of deviant behaviour

From this last quotation from Box, it can be seen that the neutralization of political protest is regarded, by critics of the therapeutic approach to social control, as an ideological, as well as a practical, accomplishment. As well as silencing political dissent in concrete terms, through the use of medication (the so-called 'liquid cosh'), it is argued that the therapeutic approach to social control 'depoliticizes' political protest by defining delinquents as ill (Zola 1972: Conrad 1975/6). As Box put it:

> Medical experts propose definitional shifts in moral, ethical and political problems into medical conditions, so that the conflicts, disputes and disagreements implicit in the former can be avoided by systematically labelling some of the antagonists. . . as diseased. In this way structural or cultural changes which might otherwise become the focal point for solving social problems are replaced with a terse medical injunction: get them and cure them" (Box 1980)

The basic problem here is that by defining conforming behaviour as healthy, and non-conforming behaviour as ill, the therapeutic approach 'naturalises' the dominant morality. It presents the dominant morality - what is in fact the product of ethical and political choices - as naturally right (see Balch 1975). Hence delinquent conduct, which may,

in some cases, be the product of a rational and "intentional repudiation of existing political arrangements" (Conrad and Schneider 1980: ch.9), is represented as irrational and determined, as the product of an underlying disorder. Political protesters are represented as "flawed individuals" (Box 1980). This process is often compared to the abuse of psychiatry once prevalent in the U.S.S.R., where political dissidents are defined as insane (see Conrad 1975). As well as justifying the detention of dissidents, this medical definition of the problem also de-politicizes deviance in an ideological sense. It disseminates the view that any way of behaving which is not in accordance with the dominant morality is simply irrational and sick. For the critics of the therapeutic aproach to crime, the dissemination of such a view is perhaps, in the long run, a greater political threat than the more concrete aspects of therapeutic control (Box 1980).

The individualization of social problems

The final criticism which I will outline is somewhat contradictary when read alongside the others. It is often argued that the therapeutic approach to social control individualizes social problems in the sense that it ignores the social structural factors which cause crime, and regards crime as the product of *'internal'* malfunctioning, whether psychological or organic (Conrad 1981: 118; Greenwood and Young 1980; Zola 1972; Balch 1975; Conrad and Schneider 1980: ch.9).

It is important to distinguish this argument from the previous one (even though the critics of the therapeutic approach often fail to make this distinction). In the case of 'depoliticization', it is

argued that crime is a *protest* against the injustices of the social order - crime is seen as rational and innocuous (or even useful). In the case of individualization, however, it is argued that crime is *caused* by the injustices of the social order - in which case crime is regarded as a genuine social problem. In this second argument, it is agreed (with the proponents of treatment) that crime is a problem which has identifiable causes; what is disputed is where these causes are to be located. Critics argue that the advocates of treatment locate the causes of crime within the individual, whereas they should be located in the social order.

> If prostitutes make a living by selling their bodies, then we must find the roots in the sexist nature of society; if women have abortions because they cannot afford to have another child, then we must look to the economic problems which capitalism engenders . . . we must look to the irrationality of the social order, not the inadequacy of the individual. (Greenwood and Young 1980: 158)[14]

The critique which I have outlined paints a grim picture of the therapeutic approach to social control. This, of course, is precisely its intention. The objective of the critique is to show that a development which is conventionally regarded as a progressive and humanitarian reform, does in fact have a more sinister side to it. The critique tries to show that far from having the beneficial consequences generally claimed for it, the transformation from a juridical to a therapeutic approach to social control has had a number of deleterious penal and political consequences. This critique has not been without effect. It has contributed to the partial decline in the popularity of the treatment philosophy in penal policy, which has occurred over the last decade or so. Treatment, where it is not

rejected altogether as proper goal of penal policy, is now regarded far more circumspectly than it was in the 1960s and early 1970s.

In the course of this thesis I will ask whether the image of the therapeutic approach to social control relied upon - and constructed by - the critique, is an accurate one. I will suggest that the reality of the therapeutic approach to crime is substantially different from the image presented by its critics.

CHAPTER 2

THE INEBRIATES PROBLEM
in the second half of the nineteenth century

INTRODUCTION

One of the ways by which the rationale and methods of penal control were partially transformed in the second half of the nineteenth century was through reformist and State interventions into the problem of habitual drunkards. These interventions can be traced back to the late 1850s when reformers, among whom medical professionals were particularly prominent, started to campaign for the establishment of a network of inebriate reformatories and retreats for the confinement and 'treatment' of habitual drunkards. This campaign led to the passing of the Inebriate Acts of 1879 - 1898' and to the establishment of a number of inebriate reformatories and inebriate retreats. By 1908 there were eleven inebriate reformatories at work, along with approximately twenty inebriate retreats and a number of other special legal provisions for those registered as habitual drunkards (Official Publications 1908; Kelynack 1904-5).

In this and the following chapter I will try to discover the rationale behind the establishment of inebriate reformatories and I will describe and examine the methods which were advocated for the 'treatment' of inebriates. I will start, in this chapter, by examining the category of 'inebriety' in detail, looking at how inebriates were distinguished, *in practice*, from others, and at why inebriates were deemed to require new forms of penal control. Before proceeding, however, I will try to show how the account of the inebriates problem

offered in this chapter fits into my more general concern with changes in the rationale and methods of penal control.

I will start by looking briefly at how the inebriate reformatory experiment has been described and explained by MacLeod (1967) and Radzinowicz and Hood (1986: ch. 9), which are the two most detailed, modern accounts of the inebriate reformatory experiment to have been published. These accounts are constructed around a few basic themes.

First, the inebriate reformatory experiment is regarded as part of a more general transformation in the direction of social policy which took place towards the end of the nineteenth century. This theme is most prominent in the account of Macleod (1967), who, incidentally, is sympathetic towards the objectives of the inebriety reformers. MacLeod regards the inebriate reformatory experiment as forming part of a more general "gradual transformation taking place in national attitudes towards the prevention and cure of social illness during the last quarter of the nineteenth century" (ibid: 215). The direction in which social policy was moving, according to Macleod, was towards welfarism. This transformation was guided by well-intentioned progressives, who promoted the concept of "government provision for chronic alcoholics" (ibid) and who wanted to put the prevention and cure of alcoholism on a public basis (ibid: 217). In order to achieve this they had to overcome not just "public apathy" and "parliamentary ignorance", but also the more positive resistance offered by "self-appointed advocates of individual liberty", who opposed any inteference with the freedom of the individual which was not justified in juridical terms (ibid: 215).[2] MacLeod concludes his article by stating that because of this

resistance, and because of certain weaknesses in the reformers' own ideas, the inebriate reformatory experiment failed (ibid: 245). For such experiments to succeed a "fundamental reappraisal of the nature of man and the character of society" was required; "such reappraisals remained a challenge for the social planners of the Welfare State" (ibid).

A second theme is that the inebriate reformatory experiment was the product of a change in the way habitual drunkards were perceived. In the accounts of both MacLeod (1967) and Radzinowicz and Hood (1986), it is suggested that there was a move, in the second half of the nineteenth century, towards a medical-determinist perception of habitual drunkards. New medical theories appreared, claiming that inebriates got drunk, not willfully, but rather because of an innate or acquired, physically-based addiction to alcohol. These theories had implications for social policy since they suggested that traditional methods of dealing with habitual drunkards were inappropriate, being based upon a misconception of the nature of the problem.
Traditionally, if habitual drunkards broke the laws against public drunkenness, they were punished by a small fine or a short period of imprisonment. If they remained within the law they would not be interfered with; they could get as drunk as they pleased, as often as they pleased. Temperance reformers might, on occasion, try to persuade them to change their habits, but they could not use any form of coercion; the habitual drunkard was free to reject the advice and exhortations of temperance reformers. This 'approach' to habitual drunkards was based upon a moralist-voluntarist perception of the habitual drunkard. The habitual drunkard was regarded as a free agent,

with the ability to decide whether or not to drink. With the shift away from a moralist-voluntarist and towards a medical-determinist perception of habitual drunkards, the need for different methods of dealing with habitual drunkards became apparent. It became clear that what inebriates required was neither punishment, nor moral exhortation, but medical treatment. Hence inebriate reformatories, where such treatment would be available, were recommended.

MacLeod, for instance, describes how, during the second half of the nineteenth century, the traditional moralistic view typified by the Temperance Movement, began to give way to an emerging scientific appreciation of alcoholism.

> Not until the last half of the 19th century did the scientific appreciation of alcoholism become general. Only then, under the guidance of a few doctors and reformers, was the image of the drunkard as a disorderly, ill-disposed social unit gradually transformed into one of a neglected patient suffering from a mental disease with well-marked clinical features. Reformers who sought to remove the moral stigma from alcoholism, and to treat the alcoholic by medical means, led the advance guard of a movement to promote prevention and cure on a public basis. (MacLeod 1967: 217)

Macleod argues that the new medical theories of alcoholism as a "nervous disease" (ibid: 224) led to the idea of inebriate retreats and reformatories, since these theories implied that "a prolonged stay in a rest home or retreat, particularly in the early stages of addiction, was an essential ingredient in the cure of an alcoholic" (ibid: 219). For Macleod, the rationale behind the inebriate reformatory experiment was to enable "the enforced detention of voluntary patients and convicted criminals for a period long enough to give hope of a cure" (ibid: 220-1).

Similarly, Radzinowicz and Hood - although they are far more sceptical about the veracity of the new medical theories - suggest

that the inebriate reformatory experiment was a direct result of the new disease theory of alcoholism which emerged in the second half of the nineteenth century.

> In the middle of the nineteenth century the view gained acceptance among certain medical authorities that habitual drunkenness was a disease. . . An excessive and uncontrollable desire for intoxicating drinks was 'symptomatic of some abnormal cerebral condition which gives it the character of a form of insanity.' The condition was not the result of drinking, rather it was to be seen as the result of the mental states which created the desire for drink. Dipsomania was a 'physical proof of mental disorganisation'. . .
> (Radzinowicz and Hood 1986: 289)

The disease theory, they suggest, led to the perceived need to keep the inebriate away from drink until a transformation in the bodily tissue took place - a transformation which would free the inebriate of his, or her, craving for alcohol.

> This concept of drunkenness led to the conclusion that the patient should be detained until he was cured. And cure could be achieved only when 'the time arrives at which all the tissues of the body have been changed, and a new tissue laid down in its place.'"
> (Radzinowicz and Hood 1986: 292)

Both of these accounts also agree that the operative theory of inebriety was a physicalist one. It is assumed - or, in the account of MacLeod, argued - that most of the reformers saw inebriety, or alcoholism, as a physically-based mental disease. This assumption is implicit in Radzinowicz and Hood's account of the rationale of reformatory treatment, which I have just discussed. It is argued for explicitly by MacLeod, who claims that the physicalist approach of the reformers contributed to the eventual failure of the inebriate reformatory experiment.

MacLeod argues that among the reformers there were in fact two theories of inebriety. The first theory, which the majority of reformers subscribed to, was a physicalist theory which "held that

alcoholism was a nervous condition and was essentially inherited or at least that a predisposition to alcoholism was passed on from father to son" (MacLeod 1967: 244). This view, according to MacLeod, led to therapeutic pessimism: "If alcoholism were only an inherited condition, then retreats were effective only in isolating alcoholics and insulating society" (ibid: 244-5). MacLeod argues that this physicalist conception of alcoholism led many inebriety reformers to virtually identify themselves with the eugenics movement;[3] this was to their disadvantage since it cut them off from the main current of public health policy. MacLeod prefers the second theory, the *environmentalist* theory, which, he argues, was subscribed to by a small minority of reformers. The environmentalists "espoused 'nurture' over nature" and argued that "alcoholism was acquired and that its cause was to be found in ignorance and the social environment" (ibid: 244). This concept of alcoholism as a "social disease" - as deriving "from the slums and anxieties of modern life" - could have led to more positive forms of intervention - an environmental approach - but, according to MacLeod:

> Because the medical profession and the 'hereditarians' dominated the reforming organisations, and because there was no sufficient psychiatric or psychological information upon which to base an environmental approach, the issue missed the main current of public health policy, and was divorced from the body of favourable public opinion. The concept of alcoholism as a 'social disease' was thus prevented from taking root. (MacLeod 1967: 245)

Finally, both accounts assume that the inebriate reformatory experiment involved a transformation in the way the problem of habitual drunkards was dealt with; a shift away from punishment and/or moral persuasion, towards medical treatment. This assumption will be considered in detail in the next chapter. I have mentioned it here,

however, in order to consider an important related argument made by Radzinowicz and Hood (1986). They argue that the original objective of the inebriate reformatory experiment was to provide medical treatment. This original objective was frustrated, however, because those habitual drunkards who were sent to the reformatories - and particularly to the State reformatories designed for criminal habitual drunkards - were the worst cases and therefore those most resistant to cure (ibid: 306f). Radzinowicz and Hood argue that as the reformatories were established, they began to be used for "the 'idle and the dissolute,' prostitutes, and the mentally defective" (ibid: 308). As a consequence of this "the purpose of the reformatories shifted from cure and reformation to discipline and incapacitation" (ibid). Radzinowicz and Hood therefore suggest that there was a gap between the medical intentions of the reformers and the actual regimes, which were more penal and disciplinary than medical. This gap is explained as a result of a distortion of the reformatory's original purpose, a distortion due to fact that the reformatories were lumbered with the most refractory and unmanageable cases (ibid: 309): "The reformatory nature of the State institution was thus distorted and it became no more than a deterrent 'punishment block'" (ibid: 310).

To summarize, in these accounts it is suggested that the inebriate reformatory experiment occurred because of a change in the way inebriates were perceived. From being perceived as willfully dissolute, the inebriate came to be regarded as a sick person, who got drunk because of a physically-based, often hereditary, addiction to alcohol, and who required medical treatment - regardless of whether he

broke the law - in order to cure his addiction and hence protect his own welfare.

It is to such 'medicalized' perceptions of delinquents that critics of the the therapeutic approach to crime object. Although the critics of medicalization have not dealt specifically with the inebriate reformatory experiment, it is clear that their general arguments are intended to apply to such developments. Hence it is possible to construct a 'critical' interpretation of the inebriate reformatory experiment, using the general arguments of the critics. This procedure is defensible, since the critique of medicalization is meant to be a general critique, which applies to all instances where the medicalization of social control occurs.

In such a critique it might be argued that the disease concept of alcoholism 'individualized' the problem of habitual drunkenness. It might be argued, in agreement with MacLeod (1967), that habitual drunkenness was a response to the dreadful social conditions engendered by industrialization, urbanization and capitalism; that "alcoholism derived form the slums and anxieties of modern life" (ibid: 245). It might be asserted that it was these social conditions rather than the drunkard himself, which required to be reformed, and that the medical conception of the problem concealed this fact.

With more novelty it might be argued that the disease concept 'depoliticized' the problem of habitual drunkards. Social historians have analysed in detail the various ways in which drinking and drunkenness were political problems in the nineteenth century (see, especially, Harrison 1971). To mention just one example: with the emergence of capitalism and industrialization - and particularly

factories - a more disciplined working class was required. The traditional drinking patterns of the working class - especially when they interfered with the efficiency of the worker - therefore became a problem. Hence the campaign against habitual drunkards might be examined in the context of a more general attempt to construct a disciplined and efficient workforce capable of manning the new factories. Hence, it might be argued that habitual drunkenness was not so much a problem for the drinker himself, but for those who benefited from the labour of factory workers. Applying the arguments of the critique of medicalization, it might be argued that this political aspect of the habitual drunkards problem was concealed by labelling drinkers as 'inebriates', thereby representing their drinking, not as an integral part of working class culture - and therefore as something with a perfectly rational basis - but simply as the product of an illness, which is clearly, and without question, irrational and undesirable.

Other elements from the critique of medicalization could also be applied to the inebriate reformatory experiment. The point, however, is that these criticisms assume that the operative image of the inebriate was in fact as described by Macleod (1967) and Radzinowicz and Hood (1986). In what follows, I will try to show that the perception of the inebriate which animated the inebriate reformatory experiment was, in fact, far more complex, and in many ways quite different, than that suggested in these accounts.

First, I will argue that it was as a public nuisance requiring social control, rather than as an alcoholic requiring medical

treatment, that the inbriate came to be regarded as a specific category of person requiring a new form of intervention. However it was not simply the inebriates inability to work efficiently, but his inability to undertake a whole range of duties required of the citizen, that made him a public nuisance. Secondly, and correspondingly, although medical theories of inebriety were developed at this time - and although these theories were, to an extent, physicalist and determinist - these theories had little *practical* importance in determining who was to be sent to inebriate reformatories. The criteria used to distinguish inebriates from others were social and behavioural, rather than strictly medical. Inebriates were distinguished from others in terms of their outward conduct, rather than in terms of their 'internal' condition (either physical or psychological). Also, although medically qualified doctors were to play a part in the ascertainment of inebriates, this was because of their 'position in the community' - which made them reliable 'judges' of the person's conduct - rather than because of any specifically medical skills which they might have possessed. This shifts our attention away from questions about the character of medical theories of alcoholism and towards asking how those inebriates who were sent to reformatories were perceived. I will try to answer this question over this and the following chapter.

THE DISTINCTION BETWEEN ORDINARY DRUNKARDS AND DIPSOMANIACS

The category of 'habitual drunkards', or 'inebriates', did not include every person who frequently got drunk. Rather, from the start of the inebriate reformatory campaign, a distinction was made between

the 'ordinary drunkard' on the one hand, and 'the inebriate' or 'dipsomaniac' on the other. Only the inebriate - or as he was sometimes known, the 'dipsomaniac' - was seen as a candidate for confinement and treatment at a reformatory. The ordinary drunkard was to be left free to do as he pleased unless he broke the laws against 'public drunkenness' or 'drunk and disorderly conduct', in which case he was to be dealt with through ordinary penal sanctions, i.e. small fines or short sentences of imprisonment.

We can begin to understand the purpose of the inebriate reformatory by asking what criteria were used, *in practice*, to distinguish the inebriate from the ordinary drunkard. If the inebriate reformatory experiment was indeed premissed upon some new medical theory of alcoholism, we would expect the inebriate to be distinguished from the ordinary drunkard in medical terms. There was in fact some attempt to do this. The rationale for the distinction was said to be medically based; the ordinary drunkard got drunk out of willful dissoluteness, while the inebriate's drinking was said to be the determined outcome of an underlying nervous disorder. This however was simply a justification offered for a distinction which was, in practice, made on non-medical grounds. Those who were sent to reformatories were never subjected to any sort of medical examination to determine whether their drunkenness was voluntary or the product of an addiction. If we wish to understand the real basis of the distinction it is necesssary to look at how the inebriate and the ordinary drunkard were to be distinguished in practice, rather than at the way this distinction was represented in medical discourse.

An early attempt to elaborate the distinction between the ordinary drunkard and the dipsomaniac can be found in the work of Alexander Peddie. Peddie, addressing the *National Association for the Promotion of Social Science* (NAPSS), was advocating the establishment of

> . . . special legalised arrangements to facilitate the exercise of control over dipsomaniacs, or insane drinkers, with a view towards their cure as well as protection. (Peddie 1860: 538)

One of the obstacles in the way of such a policy was, he pointed out, a misunderstanding about who the proposed arrangements were intended for. He therefore stressed that "it is not, as some seem to suppose, every drunkard, or every habitual or inveterate tippler, for whom we wish legal restraint" (ibid: 358). (In order to be understood, this statement needs to be placed in its historical context. Peddie was trying to distinguish the concerns of the inebriate reformatory campaign - which was concerned with a relatively small group of habitual drunkards - from the far wider concerns of the Temperance Movement. At this time the Temperance Movement was advocating radical interventions into the drink problem. Its campaign for prohibition of the sale of alcohol threatened everybody's *'right'* to drink - not just that of those who habitually drunk to excess - and was strongly opposed by powerful groups in society.[4] Peddie was now trying to stress that unlike the Temperance Movement, his concern was not with the ordinary drinker, nor even with the ordinary drunkard, but rather with a certain class of drunkard, the dipsomaniac).

One obvious reason for this restriction was that of practical feasibility: "to raise asylums for all such would be indeed a formidable undertaking" (ibid). Just as important though, the ordinary drunkard was to be excluded from the policy on principle. For Peddie

there was a clear distinction of type between the ordinary drunkard and the dipsomaniac:

> . . . between the ordinary drunkard, in whom drinking is an acquired vice, and the insane constitutional drunkard in whom drinking is a disease, it is easy to draw a line of distinction.
> (Peddie 1860: 538)

How did Peddie draw this distinction? One line of reasoning he develops is that with the ordinary drunkard, drinking is a voluntarily chosen vice, whereas the dipsomaniac has no control over his drinking: he is "destitute of any command over his own will - of all ability to resist the craving" (ibid. 539). The crucial test is the loss of self-control:

> Here, then, we are brought to view the test by which we are to distinguish the insane drinker from all other drunkards, and thus to remove all difficulty as to what should be the legal understanding in regard to dipsomania. The test is the loss of self-control. The dipsomaniac is in the condition characteristic of a large proportion of other insanities. He has lost . . . 'the distinguishing attribute of sanity, the mastery of himself'. He cannot overcome the desire for spirituous liquors which burns within him . . .
> (Peddie 1860: 540-1)

So far then, the argument seems to fit well with the conventional accounts of the inebriate reformatory programme. If we interrogate Peddie's concept of dipsomania further though, we find it simply shifts his problem to another level. It is still necessary for him to state how those with no control over their drinking are to be distinguished from those who do have control. Peddie's description of the nature of dipsomania avoids the question which he set out, and which it is essential for him to address; that of how, in practical terms, the ordinary drunkard and the dipsomaniac are to be distinguished.

Peddie offered no medical criteria for distinguishing the ordinary drunkard from the dipsomaniac. He offers some brief accounts of the drinking habits of dipsomaniacs, but since the object of the exercise is to distinguish between those in whom such habits are a vice and those in whom they result from a medical condition, then such accounts are hardly the appropriate evidence. This is particularly problematic in the case of his category of 'acquired dipsomania', "a condition in which the mere vice is transformed into a disease, and the mere vicious habit into an insane impulsive propensity, and then the drunkard becomes a dipsomaniac" (ibid. 539). Peddie fails to refer to any objective criteria, let alone a mode of medical examination, which could distinguish between those in whom drunkenness remains a vice and those in whom it has been transformed into a disease.

Peddie's disease concept offers no practical guidance then as to who is to be considered a dipsomaniac and who is to be considered an ordinary drunkard. This does not mean, however, that the distinction is purely arbitrary. Peddie does in fact offer criteria for making the distinction, but these are social and behavioural rather than medical. He states that there are an infinite variety of ordinary drunkards, of which he mentions just a few types, including "the social, jolly after-dinner drinker", the "'go-on-the-spree' or paroxysmal drinker", and "the habitually imbibing but never thoroughly intoxicated drunkard" (ibid. 538). Underlying this diversity is one common factor which distinguishes them from the dipsomaniac:

> . . . *they are on the whole able to perform their usual duties tolerably well;* some, though drunk at night can face the world pretty respectably next morning, and not only eat a good breakfast, but do duty or give good advice in the shop, counting-room, or chambers. Many hard drinkers can exercise wonderful control over themselves, choosing the time to drink and the time to keep sober;

> and while sober, *can discharge all their family, professional, social, or even religious duties - so far, at least, as outward observances go.* (Peddie 1860: 538, emphasis added)

The ordinary drunkard is characterised then by his control over his habit, but since this in itself gives us no guide to his recognition we have a list of the social duties and standards which the drinker must conform to if he is not to be classified as a dipsomaniac. Provided the drinker can go to work, do his job properly, look after his family, and *be seen* to observe his religious duties, then he "may be left untouched by legislative restraint". Such drunkards,

> . . . may be left to the teachings of morality and religion,- to the precepts and example of the wise and good. Should they carry their transgressions so far as to disturb the peace and order of society, then they properly come under the cognizance of the police and courts of law. But within this limit, as voluntary and responsible drinkers, they are beyond legislative control." (Peddie 1860: 539)

The dipsomaniac then is one who has no control, not only over his drinking, but over his conduct in general. But, out of all the drunkards that exist, how are we to recognise such characters? Peddie gives us a physical description of the dipsomaniac; he is "truly lamentable to behold, with his general broken-down aspect, feeble tremulous limbs, pale or leaden-coloured visage, and watery, lustreless eye" (ibid. 539). The characterisation of the dipsomaniac, as a sickly, feeble weakling might be seen as revealing a concern with efficiency. Industrialisation required robust, healthy workers, not these lamentable dipsomaniacs. We might also note that there is a possible role for the medical doctor here. The role of the doctor would not, however, be to determine whether the person had any underlying physical condition which could explain his addiction to

drink, rather it would be to carry out a physical examination of the person in order to see whether he displayed these signs of weakness.

Peddie never suggests, however, that such an examination should take place. There was in fact a more simple way of distinguishing the dipsomaniac from the ordinary drunkard. One simply has to look at the affect which drinking has upon the person's capacity to perform his 'social and civil duties'.

> He cannot now control his conduct, or manage his affairs; he is useless or dangerous to himself or others; disqualified for social and civil duties, a wreck of humanity, and a burden on society. (Peddie 1860: 539)

It is here then, at the level of social capacities, that the crucial test lies. The concern is not with every drunkard but those in whom drunkenness is associated with general social inadequacy. Drunkenness was important only insofar as it was the cause of, and a sign of, this inadequacy. Drunkenness which didn't impair one's ability to function, and which didn't leave one a burden upon society, was certainly not to be approved of, but it was not, in itself, sufficient grounds for legislative restraint. This shows us what the concerns of the inebriate reformers were. The main concern was not with drunkenness as such, but with inefficiency, of which drunkenness was considered to be a major cause. Hence, people could get drunk as often as they pleased, without risking legislative interference, provided their drunkenness didn't interfere with their efficiency or make them a nuisance in other ways. So long as the drunkard didn't commit a crime, didn't neglect his social obligations (e.g. to provide for his family), and didn't make himself a burden on society in any other way (e.g. by requiring public assistance) - he would be free to live as he liked

(cf. Rose 1985: 89). What mattered was not drunkenness or immorality as such, but the ability to contain the costs of one's drunkenness and immorality. Those who failed to contain the costs of their drinking habits - and only those - were to be subject to intervention.

THE SELECT COMMITTEE ON HABITUAL DRUNKARDS, 1872

From the very start of the inebriate reformatory campaign then, the concern was with social inefficiency and public nuisance, rather than with drunkenness as such. Throughout the history of the campaign the concern remained constant. This raises doubts about the claim of Radzinowicz and Hood which I discussed earlier, the claim that reformatory policy became distorted later on when reformatories were 'lumbered' with the 'idle and dissolute'. I would argue that the concern was, from the very beginning, precisely with the idle and dissolute. The inebriate reformatories were not so much lumbered with these cases, rather they were constructed for them. This can be established further by going on to consider the arguments of the Select Committee which was established in 1872 - as a result of the reformers' efforts - in order "to consider the best plan for the control and management of habitual drunkards" (Official Publications 1872).[5]

The Committee drew attention to two major problems with existing penal methods of dealing with the problem of habitual drunkards. In the first place the existing penal methods - small fines and short periods of imprisonment - were ineffective, since they failed to reform or deter the habitual drunkard (ibid: para. 3; q. 533). Proof of this was the very fact that habitual drunkards were repeatedly

convicted for drunkenness offences. If ordinary penal treatment were sufficiently reformative or deterrent, then, it was argued, there would be no such thing as multiple convictions for drunkenness (ibid: para. 3). The solution to this problem was: in the first place, legal recognition of the category of habitual drunkards, so that those who repeatedly committed drunkenness offences could be subjected to different treatment than the first-time, or occasional offender (ibid: paras. 15-18); and secondly, the establishment of state-funded inebriate reformatories where habitual drunkards could be incarcerated for a period long enough to ensure their reformation. The threat of long periods of incarceration was also deemed to be useful from the point of view of deterrence and as a means of promoting the comfort and well-being of society (ibid: Akroyd's draft report, para. 15; qq. 81, 77-85, 1194-6).

The second problem with existing penal methods was that they could only be used against a small proportion of those considered to be habitual drunkards, those who were found guilty of drunkenness offences. The committee argued that there were many habitual drunkards who, for one reason or another, never came into contact with the law. It pointed to;

> . . . a very large amount of drunkenness . . . which never becomes public . . . but which is probably even a more fertile source of misery, poverty, and degradation than that which comes before the police courts; for this no legal remedy exists, and without further legislation it must go unchecked.
> (Official Publications 1872: para.9)

Or as one witness put it;

> The habitual drunkard whom we wish to treat. . . very rarely comes before the justices; he is cunning enough to keep out of the way; it is the ordinary drunkard who comes before the justices.
> (Official Publications 1872: Dr. Bree, q. 889).

The solution offered to this problem was the establishment and licensing of a separate class of privately-funded inebriate *retreats* for the confinement and treatment of non-criminal habitual drunkards (see Peddie 1872: paras. 2-5). Confinement in a retreat was to be governed by two procedures. First, a person could voluntarily declare himself an habitual drunkard and enter a retreat. Having done this however, he would then be liable to detention, as if he had been committed through the second procedure (rec'n. 2-3; there was a precedent for this proposal in the procedures of the Contagious Diseases Commission, see q.729). Second, a person could be committed to a retreat, in a procedure analogous to that of the committal of lunatics to asylums. The person could be committed,

> . . . on the application of their friends or relatives, under proper legal restrictions, or by the decision of a local Court of Inquiry, established under proper safeguards, before which, on the application of a near relative or guardian, or a parish or other local authority, or other authorized persons, proof shall be given that the party cited is unable to control himself, and incapable of managing his affairs, or that his habits are such as to render him dangerous to himself or others; that this arises from the abuse of alcoholic drinks or sedatives; and he is therefore deemed to be an habitual drunkard. (Official Publications 1872: rec'n. 3)

It was proposed that such persons be confined for a period not exceeding twelve months and that control of their property should be placed with a trustee or guardian (rec'n. 4).

It appears then that a major objective of the committee was to construct a new approach to the control of habitual drunkards. This was not to replace the juridical approach, rather it was to operate alongside it, dealing with those cases which could not be adequately dealt with through juridical principles. In the process, juridical principles would be modified, but not totally displaced.

This new approach to the problem of habitual drunkards can be distinguished first, in terms of its form; instead of small fines and short periods of imprisonment we have long periods of "punitive treatment" in reformatories.[6] Secondly, it can be distinguished in terms of its scope, its target population was not those who committed drunkenness offences, but rather those who, through a variety of procedures, were declared to be habitual drunkards. In the following chapter I will examine the form which intervention took; here I am concerned with the second aspect of this new form of intervention, its difference in scope.

As we saw in chapter one, in the juridical approach to social control, only those who break the law are liable to interference with their liberty. In the case of drunkenness, only those who transgressed the laws against 'public drunkenness' and 'drunk and disorderly conduct' could be subjected to penal control. The target population for the new, reformatory approach to the problem of habitual drunkards differed in two respects. First, it did not include all drunkenness ofenders, but only 'recidivist drunken offenders'. Secondly, it included 'non-criminal inebriates', persons who were regarded as inebriates even though they had not been convicted of a drunkenness offence. I will now look at these two categories in more detail in order to see what they tell us about the rationale behind the inebriate reformatory experiment

(a) The distinction between the recidivist and the occasional drunken offender

First, not all drunken offenders were to be included within the category of habitual drunkards. The first time or occasional offender was to be excluded, only the recidivist drunken offender was to be deemed an habitual drunkard. The committee recommended that those convicted of three drunkenness offences within a period of twelve months should be required to find "sureties for sobriety and good conduct for a fixed period"; if such sureties could not be found, or if the conditions were subsequently breached, then,

> . . . he should be deemed and registered as an 'Habitual Drunkard' and as such may be sent to an industrial inebriate reformatory by a magistrate's order for a term of not less than three nor more than twelve months, the time to be governed by the frequency of the offence" (Official Publications 1872: paras. 15-18)

We can note then that the recidivist drunken offender is not to be subjected to any medical or psychiatric examination to determine whether his drunkenness is the result of an underlying disorder, physical or mental. Rather he is to be declared an habitual drunkard solely on the basis of his recidivism. No knowledge of the person as an individual is necessary, all that one needs to do is count his convictions: "I would lay it down that if the man was brought before the magistrates more than a certain number of times he would be deemed an habitual drunkard" (ibid: q. 1905).

This concern with recidivist drunken offenders owes little, if anything, to developments in medical theory. In order to explain this concern it would therefore be necessary to turn our attention away from the development of a disease concept of inebriety and to look at a quite different development which was taking place in the second

half of the nineteenth century - the developing concern with recidivism - or with habitual criminals.[7] The connection between the habitual drunkards problem and the more general problem of recidivism was made explicit by the the committee member, Akroyd.

> . . . your attention has been called to the question of dealing in this country with habitual criminals in a different way from that in which you deal with ordinary criminals; in your judgement, would the same sort of dealing be desirable with habitual drunkards as well as with the habitual criminals?" (Official Publications 1872: q. 1421)

To subject recidivists to special forms of penal control was to go against juridical principles, which - as we saw in chapter one - declared that a person should receive a punishment proportionate to his offence and that the punishment shouldn't be varied to take account of who the offender was or the likelihood of his re-offending. Nevertheless, from the second half of the nineteenth century, through to the early years of the twentieth century, special legal provision was made for the incarceration and supervision of recidivists (Radzinowicz and Hood: 1986: ch.8). This change in the direction of penal policy was partly the result of increasing political concern with the problem of the class known, variously as '*the residuum*', or the *criminal class*.

In the second half of the nineteenth century the working class was increasingly seen as being divided into a number of distinct sub-classes.[8]. While the better-off sections of the working class had, to a considerable extent, adapted their lifestyle and personal conduct to the demands of urban, industrial society - and had 'internalised' values such as lawfulness, sobriety, self-help, respectability, domesticity, thrift and 'rational' forms of recreation - the

'residuum' had not. The residuum - or as Booth was to call them "the lowest class of occasional labourers, loafers and semi-criminals" - remained unattached to these social values. They were therefore seen as representing a threat to the social order. One of the major concerns of social policy in the second half of the nineteenth century was with how to contain this threat.

One method of controlling the residuum was to use the deterrent effect of punishment. This method was increasingly regarded as insufficient, however, for a number of reasons. First, as we saw in chapter one, deterrence worked, at least partly, through the disgrace of punishment; to be sent to prison was an afront to one's self-respect. The residuum, however, were regarded as having no self-respect in the first place; indeed, this was one of their defining features. Having no self-respect they could not be deterred through the threat of ordinary punishment (Official Publications 1872: q. 1599).[9] A second problem was that the types of crimes which the residuum tended to commit were petty crimes (see Radzinowicz and Hood 1986: 241-3), petty larceny and nuisance crimes, such as 'being drunk and disorderly. On the principle of proportionality such offences could be punished, at most, by short sentences of imprisonment. These sentences were regarded as being too short for deterrent purposes.

An alternative method of dealing with the residuum would be to try to 'reform' or 'discipline' them, to install within them the values of sobriety, domesticity, self-help, and so on. As we shall see in the following chapter, this is the strategy which was suggested by the inebriety reformers. The existing juridcial approach to the problem was deemed to be useless for the purposes of reform. First, because

the short sentences of imprisonment which the habitual drunkard would receive, at the most, were too short for the purposes of reform, and secondly, because the regime of prisons was unsuitable for refomative purposes. What was therefore required was longer periods of confinement in new 'reformative' institutions. Such confinement would also act as a more effective deterrent and would also incapacitate many recidivists, thereby containing the threat which they posed to the social order. It is in this context - rather than in the context of new medical theories of alcoholism - that the inebriate reformatory experiment can be best understood.

The concern with habitual drunkards can be seen then as an aspect, and a central one, of this more general concern with the residuum. Not only, as I will argue in the next chapter, was 'treatment' conceived of in terms of installing, within the inebriate, central social values; also, the category of habitual drunkards was defined in the same terms as the residuum. The habitual drunkard was defined not so much in terms of his drunkenness, but rather in terms of his general lack of attachment to social values and the social order The inebriate's lack of sobriety was just one aspect, albeit an important one, of his more general lack of 'socialization'. So throughout the enquiry of the 1872 Committee the habitual drunkard was described in the following terms: Habitual drunkards often "go about hawking" (q.6); they "are generally weak and of weak intellect" (q.27); they are not the stable population, but passers through, - they are tramps (q.62-4); drunkenness is associated with petty larceny, disorder, etc. (q. 134); "Sixty-nine per cent of the persons convicted of drunkenness could neither read nor write; and ninety-one per cent...never went to

any place of worship" (q.134); "The habitual drunkard is an idle man" (q.1294); he has no self-respect (q. 1599).

(b) The non-offender inebriate

The other group whom the committee wanted to subject to special forms of control as habitual drunkards were those who, without committing any offence, were nevertheless deemed to require detention because their habitual drunkenness had left them unable to perform their social duties or to manage their affairs. This proposal was far more controversial than the proposal to confine habitual drunken offenders. While the proposal to confine recidivist drunkards departed considerably from juridical principles, it could at least be argued that these offenders had previously infringed definite laws. The proposal to confine non-offender habitual drunkards could not be justified in this way; the proposal conflicted radically with the basic liberal tenet, that a citizen could only be deprived of his liberty on grounds that he had committed a definite illegal act.

There was, however, one widely recognised exception to this rule: the power to confine the insane. While not wholly uncontroversial, this power has generally been acceptable to all but the most staunch defenders of the liberal principles. A major reason for this is that special rules for the insane can be justified without stepping outside the boundaries of liberal ideology. As we saw in chapter one, the liberal/juridical approach to social control presupposed that individuals were self-governing, rational individuals. The insane, however, clearly lacked either free will and/or rationality. The

principles which guided the control of normal persons could therefore be deemed inapplicable to the insane.

One way of arguing for legal provisions for habitual drunkards, without confronting liberalism head-on, was to argue for some sort of affinity between inebriety and insanity. I would argue then, that it was this special legal status of the insane, as much as any medical consideration, which led the reformers to their persistent comparisons of the insane person and the habitual drunkard. It should be made quite clear though that the conventional view was not that the habitual drunkard was insane; to the contrary it was persistently pointed out by the witnesses at the inquiry that - apart from short periods when the habitual drunkard was suffering from delerium tremens - the habitual drunkard was *not* insane (Official Publications 1872: para. 12, qq. 480, 672, 1081). In fact, the practice of confining habitual drunkards in lunatic asylums, which sometimes occured, was criticised by the reformers as inappropriate (ibid: para. 12, qq. 455, 460, 1187-9). Also a distinction was often drawn between the small minority of inebriates who were "clearly mad" and hence could be sent to an asylum, and those who were not, and hence required different treatment (ibid: q. 240). The actual argument used, was that habitual drunkenness was a condition *analogous* to insanity; inebriety was a sign of impaired mental function, but not of insanity (ibid: q. 3208). It was argued that because of this *affinity* between inebriety and insanity, habitual drunkards should be dealt with through procedures *similar* to those used for confining the insane.

The question of the relationship between the insane and the habitual drunkard was addressed by Peddie during a discussion of whether or not

the proposed inebriate reformatories should be under the control of the Board of Lunacy. Earlier in his testimony, Peddie was asked whether treatment or punishment was most suitable for the habitual drunkard; he replied that since;

> . . . habitual drunkenness . . . is a form of insanity, or at least something *closely allied to insanity*, then the habitual drunkard is more properly a subject for *care*, as it were, in a hospital, than a person for punishment in a gaol; yet at the same time there must be a certain amount of reformatory treatment entering into every case. . . (Official Publications 1872: q. 954, emphasis added)

Peddie went on to argue that the proposed institutions should be under the control of the Board of Lunacy, but qualified his argument as follows.

> I come somewhat unwillingly to this conclusion, and I think it would be very desirable to keep up a clear distinction between such institutions and asylums for the insane. We treat the insane as people labouring under disease; . . . there is nothing disgraceful in their condition . . . we avoid as far as we can all signs of incarceration, and shun the very words which indicate the existence of what we are constantly trying to reduce to a minimum. But I think we should be obliged to deal with the drunkard somewhat differently. He is detained against his *will*, and if supported by the country is forced to work, in spite of the fact that *he is still legally sane*, and has possession of his *civil rights and responsibilities*; there is something therefore *disgraceful* about his position, and *something penal in his treatment*. . .
> (Official Publications 1872: q. 1213, emphasis added)

The important question to ask, with regard to this second category of inebriates, is how they were distinguished - in the absence of any firm criteria such as the commission of frequent drink-related offences - from others. We should recall that habitual drunkenness was not in itself considered sufficient grounds for intervention, since ordinary drunkards were to be distinguished from inebriates.

As we saw earlier, apart from those cases where the person voluntarily declared himself to be an habitual drunkard, the decision was to be made by a Court of Inquiry. In making its decision the Court

was to consider whether there was evidence that the person was "unable to control himself", "incapable of managing his affairs", or "dangerous to himself or others", and that this was due to "the abuse of alcoholic drinks and sedatives" (Official publications 1872: rec'n. 3).

So, despite the claims of some witnesses - that the ordinary drunkard and the dipsomaniac could be distinguished on the basis of a medical diagnosis (ibid: qq. 560, 954, 1059, 1341) - the criteria to be used in practice, for ascertaining inebriates, were in fact social and behavioural. Nevertheless, it seems to have been generally presumed that the opinion of medical professionals on these questions would be, in some sense, authoritative. Hence it was claimed that 'medical men' would have no difficulty distinguishing between habitual drunkenness which results from a vice and that which results from a disease (ibid).

This view was disputed, however, by a number of medical witnesses, such as Dr. White, "an ordinary doctor", who claimed that it was, in fact, "impossible for medical men to tell the difference between habitual drunkenness caused by disease and that caused by bad habits" (ibid: q. 374). Similarly, Dr. Anstie argued in favour of a more simple test, based upon the same logic as the distinction between the occasional and the habitual drunken offender: "I think you must have as your test the frequency with which a man has broken down, you must make some rules independent of abstruse medical rules" (ibid: q. 567). In the light of this difference of opinion it is useful to look at what, according to its advocates, medical diagnosis consisted of. Answering this question is difficult because, despite their faith in

the ability of medical men to 'diagnose' inebriety, none of its advocates of medical diagnosis tell us how diagnosis was to take place. What we are told, however, is that it is the *practical experience* of the medical man which makes him particularly qualified for the task of distinguishing the inebriate from the ordinary drunkard. The greater competence of the physician as against any other educated person, was explained then solely as a result of the phyician's greater practical experience; no reference is made to any distinctive *medical skills* which may be necessary. Hence to the proposition that "the boundary between vice and disease... is one which might be left to the educated mind", Dr. Winslow replied,

> No; I think that a medical man who has had practically to deal with these cases has very little difficulty in coming to the right conclusion as to whether the boundary line has been overstepped, in other words, whether the condition is that of normal or abnormal drunkenness. . . . Experience gives him an additional sense, and enables the physician to come to the right conclusion; he ought rarely to commit a mistake in his diagnosis.
> (Official Publications 1872: q. 1351)

Elsewhere, we get a clue as to the type of practical experience which is so essential to the task of diagnosing inebriety. It is not so much the *clinical* experience of the physician which is of value; rather it is his intimate knowledge of the social situation of the drunkard. Hence Dr. Bree argued that physicians can easily *detect* the habitual drunkard, even among the poorer classes;

> . . . the parish surgeon knows every person in the parish, and all the circumstances, and sees the misery of the wife and children, and knows the cause of it, and his attention is very early drawn to it."
> (Official Publications 1872; q. 859)

This quotation gives us a clue then as to the criteria which the doctor had in mind when deciding whether a person was an inebriate or an ordinary drunkard. The decision is not to be made upon the basis of

physical or mental tests, rather the doctor must take into account "all the circumstances". But what are these circumstances? It seems fairly clear that the basic test was one of efficiency and ability to perform one's obligations. Hence the non-criminal habitual drunkard was defined in terms of the affect which his drinking had upon his capacity to function efficiently, without becoming a nuisance and a burden upon his family, employers and society. Hence, in deciding whether to classify a drinker as an inebriate, the doctor would have in mind a distinction between the "*regular drunkard*, i.e. one who gets drunk but can carry on his business should not be interfered with" (q.594) and habitual drunkards, who are "...the cause of ruin to their families, of grevious injury as well to their relatives as to their creditors" (q.1900). The habitual drunkard "squanders his property, mismanages his property, places his family in trouble or distress, or transacts his business prejudicially to the interests of his family or his creditors, or...he uses intoxicating liquors to such an extent as to increase the danger of ruining his health, and shortening his life" (ibid).

We might state then that along with the concern with the residuum, the reformers were concerned with those members of the skilled working class and of their own middle-class, who, through habitual drunkenness had became nuisances to their families and potential public nuisances. These twin concerns - with the residuum and with the inebriates among the skilled labourers and the middle-class - can be seen as dual aspects of the one problem. The residuum were defined in terms of their lack of attachment to central social values, such as sobriety, respectability, self-help and thrift. The non-criminal inebriates were

seen, not so much as unattached from the social order, but as in danger of becoming unattached through their habitual drunkenness. Since the central social values were seen as closely connected (see Nye 1984: ch.5) the person who had lost the value of sobriety might be seen as in danger of losing his attachment to other social values, thrift, self-help etc. The distance between the drunkard, the squanderer, and the idle pauper was a short one, and the habitual drunkard was well on the way to adopting the moral standards of the idler.

The residuum then, needed to be *attached* to the social order. The better-off habitual drunkards required that their ties to the social order be strengthened. The problems which the recidivist drunkard and the better off habitual drunkard were similar then, but differed in the crucial aspect that the recidivist required integration into a culture which he had never been a part of, while the better off habitual drunkard required a strengthening of his ties to the culture, ties which already existed. The recidivist, in short, needed to be completely socialized, while the better-off drunkard needed some milder form of socialization. This difference, as I will point out shortly, was clearly reflected in the proposed solution to the problem.

SUBSEQUENT HISTORY OF THE PROPOSALS

A Bill was subsequently introduced to carry out the the committee's recommendations, but it failed to get beyond a second reading (Official Publications 1893/4: appendix 6). In 1877, amid fresh concern with the problem of intemperance, a new Habitual Drunkards

Bill was introduced. This eventually became law in 1879, but the original Bill's proposals were radically diluted through amendments (ibid). The Habitual Drunkards Act, 1879 only made provision for the licensing of *retreats*, established as 'private speculations', to which 'habitual drunkards' could be admitted on their own application (ibid). The original Bill had also proposed the establishment of *reformatories*, funded by local rates with contributions from the Treasury, to which criminal and non-criminal habitual drunkards could be committed. These compulsory procedures were dropped, as were the Bill's proposals regarding procedures for the recapture of escaped patients.[10] It was widely agreed that without the power to "recover patients who have escaped" the potential of inebriate retreats to "cure" habitual drunkards was severly undermined (Official Publications 1893/4: para. 9).

By and large then the reformers failed, at this stage, to achieve their main objective, i.e. a substantial extension of the power to confine and control inebriates. Apart from libertarian objections, the political unwillingness to compel local authorities to undertake the financial commitment involved in the establishment of inebriate reformatories was a major contributing factor to the failure of the reformist proposals.[11] Along with the refusal to allow compulsory committal, the fact that retreats were to be privately funded, meant that the admission fees were often high, so that only those with considerable means could enter inebriate retreats for 'treatment'. Far from the control of the residuum which the reformers had sought, the Habitual Drunkards Act 1879 led only to the establishment of - in the

words of Radzinowicz and Hood (1986) - "temporary refuges for gentlemen alcoholics".

Many of the reformers' demands were, however, eventually legislated for in the Inebriate Act, 1898.[12] In confirmation of what I argued earlier, the new concern with habitual drunkards in the 1890s formed part of a more general concern with *habitual criminals* and hence with the 'criminal class' or 'the residuum'.[13] The problem of inebriates was so closely identified with the problem of habitual criminals that it was possible to address these different aspects of the one problem through the same official enquiries. The nature of the problem is well revealed by the title of the 1895 Scottish Departmental Committee which inquired into the problem of "Habitual Offenders, Vagrants, Beggars, Inebriates, and Juvenile Delinquents" (Official Publications 1895).[14] And in 1896 inebriety reformers were arguing that recidivists and habitual drunkards could be considered together (Renton and Yellowlees 1896). Support for this contention came from the Prisons Committee, which in 1894 defined the habitual criminal in the following terms:

> . . . there is a large class of habitual criminals not of the desperate order, who live by robbery and theiving and petty larceny, who run the risk of comparitively short sentences with comparitive indifference. They make money rapidly by crime, they enjoy life after their fashion, and then on detection and conviction they serve their time quietly with the full determination to revert to crime when they come out. We are inclined to believe that the bulk of habitual criminals are composed of men of this class...further corrective measures are desirable for these persons...they are a nuisance to the community. (Official Publications 1894, quoted in Renton and Yellowlees 1896: 92)

After suggesting that such cases required special treatment, the committee went on to argue that,

> Under this head should be included most prisoners sentenced

> primarily for drunkenness. They are not criminals in the ordinary sense and should stand by themselves in a special category. (ibid: 93)

The 1898 Act allowed for the compulsory committal to inebriate reformatories of two classes of inebriate. The first class were multiple drunkenness offenders, the second class consisted of offenders (convicted of any offence) who were proved to be inebriates. Offenders in both classes could be committed to an inebriate reformatory for a term not exceeding three years; for those in the second class this 'reformatory treatment' could be imposed either in addition to, or instead of, being sentenced for their actual offence (this was known as a 'dual-track' system and is also found in legislation concerning 'persistent offenders' from the same period - Radzinowicz and Hood 1986: p.305 & ch. 8; Official Publications 1908: ch. 3). Along with this, the Provision of Meals Acts 1903 and the Prevention of Cruelty to Children Act 1904, provided for the detention in inebriate reformatories of those found guilty of child neglect or cruelty to children, where such neglect or cruelty was considered to be due to inebriety.[15]

This legislation affected the position of habitual drunkards who had been found guilty of a criminal offence. No provision was made, however, for the compulsory detention of those who might be considered to be inebriates, but who had not committed any offence. Provided the drinker could remain within the law, their liberty could not be interfered with - unless they voluntarily signed away their freedom - no matter how much of a nuisance or a burden they were.[16] There was still considerable dissatisfaction among the inebriety reformers then, who continued to demand a means of controlling non-offender

inebriates. The following from the Departmental Committee on the Inebriates Act, 1908, echoes the demands of the previous generation of inebriety reformers.

> There is, however, a class of inebriates who are numerous, whose inebriety is the cause of great distress, misery, poverty, and degradation, to themselves and their families, and who are excluded from the operation of both these Acts. Any person who drinks to excess, without committing a public offence or crime, can continue his drunken habits indefinitely, notwithstanding that he may produce, over many years, untold misery to his family and ultimate expense to the community. Such persons often, at length, commit offences, and then may be dealt with under the Act of 1898; but, in very many cases, they pursue their disastrous habit until they die of disease engendered by it. There is no reason to doubt that if there existed means by which could be placed compulsorily under control at an early period in their career, a large proportion of them could be restored to *decency* and *usefulness*, and an incalculable amount of misery and poverty could be prevented. At present the only possibility of control for such persons is the somewhat remote chance that he may be persuaded or coerced into making a 'voluntary' application for admission to a Retreat" (Official Publications 1908: para. 18, emphasis added)

COMMITTALS TO INEBRIATE REFORMATORIES

The gender imbalance

The most striking feature of the population actually committed to inebriate reformatories is that the vast majority were women. In the inebriate reformatories established under the 1898 act there was accomodation for 165 males, and 1,021 females (Official Publications 1908: q. 92). In the Marlborough St. Court, for the nine years to April 1908, 140 persons were sent to homes as habitual drunkards; of these 17 were men and 123 women. In the Tower Bridge Court, for the same period the figures were 15 men and 123 women (ibid: q. 304). An understanding of the causes of this ratio will bring us closer to understanding the purpose of the inebriate reformatory, and will

confirm my contention that the concern was not with drunkenness in itself, but rather with the drunkard as a public nuisance.

There is no single explanation for the gender imbalance between male and female commitals to inebriate reformatories.[17] It does not appear to have been the result of a deliberate decision; the inebriate reformatory campaigners had not given the impression that reformatories were intended for women rather than for men. If anything, the inebriety reformers who gave evidence to the 1872 Habitual Drunkards Committee appeared to have male, rather than female, inebriates in mind. There were very few references to female inebriates specifically and there was only one witness who declared a specific interest in female inebriates. This was Dr. Druitt who, unlike most of the other witnesses was concerned primarily with habitual drinking among the upper classes. He argued that there was a great deal of "secret drinking" among upper class women (Official Publications 1872: q. 3028 f). Unlike the social imbibing of upper-class men, this secret-drinking was (by definition) *anti-social*, and was therefore likely to be the sign of inebriety. This argument doesn't explain the subsequent gender difference in reformatory committals. In the first place it was not upper-class women, but those from the poorest sections of the labouring class who were sent to reformatories. Secondly, they were sent there after receiving a number of convictions for *public* drunkenness offences (i.e. they were not secret drinkers of the type encountered by Dr. Druitt).

It should also be pointed out here that the inebriate reformatories were not constructed according to any systematic plan. The inebriates legislation permitted, rather than ordered, the establishment of

inebriate reformatories, with the result that reformatories were constructed through local initiatives and philanthropic endeavour. So, the facts: (i) that the bulk of reformatory provision was for female inebriates and (ii) that females constituted the vast majority of committals, were in a sense accidental, rather than the result of an explicit policy. But while there is no single explanation of the imbalance, I will argue that the various factors which contributed to the imbalance were related, and that this relationship can be understood once we realise that the purpose of the reformatories was to *contain and discipline* those who were deemed to be a public nuisance. The following then is an account of the factors which, taken together, contributed to the gender difference; I will try to show how each was related to the general concern with inefficiency and public nuisances.

Inebriety, child neglect, and neglect of domestic duties

The following are two fairly typical descriptions of women who were sent to inebriate reformatories:

> Age 36; started to drink to excess 14 years ago, continued 7 years, then for 3½ years was steady, afterwards relapsed, and for 3½ years had been drunken. She frequently accosted men in the street in order to obtain drink. There were six children involved, the oldest 13 years, the youngest one month (this child was blind with gonorrheal opthalmia).
> The husband was a respectable, hard working man. Average earnings 28 shillings weekly. The woman had pawned the clothing and household goods as far as possible; the other furniture and windows broken. Rooms dirty; bedding black with dirt
> The children were fairly nourished, but they were very dirty, as was their clothing. That there condition was not more deplorable was due to the efforts of the mother's sisters.
> Committed for 3 years detention on 18 October 1907, the previous convictions were:-
> October 1904 - Woman reprimanded by magistrates and given a chance to reform.
> November 1904 - Husband got a separation; remained apart for a few months.

February 1906 - Six months for neglect.
1906-1907 - Several fines for being drunk and disorderly."
(Official Publications 1908: evidence of R. J. Parr, Director of the NSPCC, which was responsible for the committal; described as a typically bad case).

Aged 36; drunken for 14 years. Husband steady and industrious, earning 38 shillings weekly, - an elder boy also gave 10 shillings weekly for his lodgings.
Three children effected, 15 years to 4.
The children were clean, well nourished, and fairly clothed, but this was owing to the father's attention. He had also kept the house clean and fairly tidy. The women entirely neglected her home and all its duties; would do no cooking.
She stopped away daily for hours, and frequently for one or more nights.
She had pawned clothing and many other things, and borrowed money all round, and nearly lost her husband his job through his being pestered at the works for repayment
One month's imprisonment; three years detention on 4th July 1906.
Previous convictions:-
In 1902 prosecuted and convicted.
In 1903 prosecuted and reprimanded only.
In 1904 3 months imprisonment."
(ibid. described as a less serious case).

The gender imbalance can be partly explained by the activities of the NSPCC who claimed responsibility for 316 committals. The NSPCC's campaign was directed at mothers whose habitual drunkenness left them unable to perform their domestic duties. Inebriety in mothers was considered particularly problematic as the mother was the shaper of the child's and the husband's domestic environment. If the mother didn't perform her domestic duties well, the enviromment would be disorderly, dirty, and unhealthy. And since, as I will argue in the next chapter, a squalid and disorderly environment was seen as a chief cause of inebriety and other unhealthy habits, habitual drunkenness in the mother could lead to the whole family becoming a burden upon society.

Inebriety and prostitution

Another way in which a concern with female inebriates was explicitly expressed was in the provisions of the Licensing Act of 1902 which enabled a magistrate to send an inebriate wife to to a retreat in lieu of a separation order (Official Publications 1908: q. 278). There was no reciprocal power with regard to inebriate husbands (ibid: q. 288). This power was seldom used because it was still necessary to obtain the wife's consent (the admission would be 'voluntary', ibid: q. 278). This provision was not in itself responsible for the gender imbalance; it does however give us a clue to the extraordinary concern with female inebriates. The Inspector of Inebriate Reformatories, Dr. R. W. Branthwaite, had this to say:

> Of course the power is really a very humane and a very useful one, if it could be only more generally applied, because an inebriate wife if separated from her husband usually becomes immoral and sinks to the lowest depths. (Official Publications 1908: q. 278)

The 'lowest depths' refers, as we might guess, to prostitution, and in particular to street prostitution. As I have suggested earlier, and as Nye points out in his book 'Crime, Madness and Politics in Modern France' (1984), late nineteenth century medical men and philanthropists hardly distinguished between the various 'social pathologies', tending to see them as aspects of the one *social problem*. The link between one problem, such as inebriety, and others such as prostitution, crime, pauperism, etc. was easily made; just as the bourgeois values of sobriety, thrift, domesticity and self-help were seen as inextricably linked. This statement from the Departmental Committee on the Inebriates' Acts, 1908 is typical.

> Many inebriates exhibit lack of self-control, not only in indulgence in drink, but also in abhorrence of steady employment, in excessive sexual indulgence, in violence of temper, and in other

ways. (Official Publications 1908: page. 6)

In this statement we find the problem of inebriety being closely linked to the problem of prostitution and to other immoralities. In fact, there is strong evidence to suggest that the women confined in inebriate reformatories tended to be confined for prostitution just as much, or even more so, than for their drinking habits. This concern for prostitution goes a long way then towards explaining the gender imbalance in reformatory committals.

In the NSPCC committals cited above we can detect a hint of concern with street prostitution: "she frequently accosted men in the street in order to obtain drink". Others who testified before the 1908 committee revealed a similar concern. The following is from the metropolitan magistrate, Mr. E. Baggallay:

> . . . we should keep the streets and other public places free from habitual drunkards, and particularly women, who are a very great trouble; and there is no doubt with regard to women that they influence others. As I understand it at the time the 1898 Act was passed it was very largely supported on the ground that it would assist the magistrates and the police in keeping the streets clear. (Official Publications 1908: q. 302)

Dr. W.C. Sullivan, the Deputy Medical Officer at H.M. Prison, Holloway, argued that a large number of female prisoners who had suffered from delirium tremens (a condition closely associated with inebriety) were prostitutes (ibid: q. 834). For another witness the slide from inebriety to prostitution was practically inevitable; inebriate women "pawn their childrens' or husband's clothes, and eventually the man gets a separation, and then that woman, what happens to her - the street" (ibid: q. 1476). Another witness, described the type of case which was dealt with in the women's inebriate reformatory at Langho, in Lancashire, in the following

terms: "The great majority of them are of the lowest class of street harlots, and of the lowest slum population of the large towns" (ibid: q. 1996).

The connection between inebriety and prostitution was most explicit though in the evidence of Thomas Holmes, a Police Court Missionary and Secretary of the influential penal reform body, the Howard Association. Incidentally, Holmes' argument also shows that advocation of inebriate reformatory treatment was by no means dependent upon a deterministic outlook. He claimed;-

> The police court inebriates who come under that Act are first immoral. I have watched the lives of hundreds of them. They come on the streets absolutely of their own accord, of purpose aforethought; no other life will suit them; they are not there because of social and industrial circumstances. The women who come within this Act and who so frequently appear at the police courts are simply absolute prostitutes and nothing else - that is eighty per cent of them... the whole bulk of young women that are charged in police courts are activated first by lust." (Official Publications 1908: q. 1488)

Holmes spent most of his testimony moralising about prostitution. The first impression one gets from reading his testimony is that he has turned up at the wrong committee; indeed his interrogators found it necessary to inform him that the concern of the committee was with inebriates and not with prostitution (ibid: q. 1511). To this Holmes replied that with most arrests of women for drunkenness offences, and subsequently with most of the committals of women to inebriate reformatories, drink was only the formal reason for arrest and committal. The real reason was prostitution.

> "... they get drunk enough to get into contact with the police and get locked up. For the drink, as drink, very few of them have any particular passion; it serves their purpose by getting them into contact with men" (Official Publications 1908: q. 1511)

Elsewhere though, Holmes describes the relationship between inebriety and prostitution in different terms. Drink is not simply used for business purposes, rather the lust for drink and the lust for sex are connected at a deeper level: "... drink brings them into contact with the police. The connection of the two *passions* makes them very objectionable and makes them interfere with men" (ibid: q. 1489). And finally, when asked whether confinement in inebriate reformatories would cure them, Holmes reply was "I do not know about that, but the streets would be cleaner" (ibid: q. 1518).

The concern with street prostitution intersects clearly with the concern with the residuum. Street prostitutes were the most visible sign of the existence of this class; they were seen as drunk, morally loose, idle (prostitution was not considered to be work) and undomesticated. The connection betweeen the problems of prostitution and that of the residuum comes out clearly in the statement above linking 'the *lowest* class of street harlot' with the 'lowest slum population of the large towns'. Nor was the problem too far removed, in the eyes of the reformers, from the problem of neglect of children and domestic duties. As we have seen, the women who neglected her children and husband, was in danger of being thrown out by the husband. From there, the next stage was almost inevitably that of street prostitution. The women who failed to keep a good home, the street prostitute and the inebriate were hardly distinguished at all in the minds of the reformers; the problems generally went together and had to be tackled together. What was required was not cure of the inebriate, but the total reformation of the inebriate women.

The correspondence between female inebriety and reformatory treatment

The gender imbalance in reformatory commitals might also be partly explained by looking at how a particular conception of female inebriety connected with a particular conception of the nature of reformatory treatment. I will briefly outline this argument here, although it will become clearer after the next chapter, when I will have described the favoured methods of reformatory treatment.

With regard to the nature of female inebriates, it was presumed that inebriety in a female was more the determined outcome of circumstances, environmental and otherwise, than was inebriety in men. The argument that habitual drunkenness was, in part, not willful but the product of one's environment, was not applied evenly to men and women. Like their conduct in general, the drinking behaviour of men was likely to be seen as more voluntary than determined, even in the case of men labelled as dipsomaniacs. The drinking behaviour of women though, was likely to be seen as more determined than voluntary (cf. Allen 1987). This was related to a more general conception of female nature, or at least of the nature of female deviants: "I think the environment of a woman is very important because she seems to take on the colour of her environment more than men do" (Official Publications 1908: q. 700).

The reason for this leading to a greater likelihood of women being subjected to reformatory treatment had nothing to do, however, with arguments to the effect that since their drinking was determined, they were therefore ill and should not be punished. Rather it was thought that since women were more easily shaped by the environment, and by moral suasion (ibid: q. 704) than were men, they could be more easily

managed through the relaxed discipline of the reformatory, than through the harsh discipline of the prison. The particular conception of female inebriety had to intersect then with a particular conception of the nature of reformatory treatment before it could be translated into a gender difference in actual committals (cf. Allen 1987). As we shall see in the next chapter, reformatories were distinguished from prisons in terms of the type and degree of discipline which they imposed. Prisons were characterisaed in terms of their harsh disciplinary regimes, which were more suitable to the wilful conduct of the male inebriate, whereas the milder discipline of the reformatory, relying upon environmental manipulation and moral suasion, was seen as more suitable for the punishment and reformation of the *less wilful* female inebriate.

The confinement of the residuum

To move on and look at the population of the inebriate reformatories in more general terms, it is clear that the reformatories were used as a tactic in the attempt to contain and discipline the residuum. The reformatories were used to incarcerate people from the poorest sections of the working class: the unemployed, paupers, vagrants, tramps; all those who obtained no benefit from the existing social order and who correspondingly had no attachment to values which helped uphold that order. These were 'the dangerous classes'; the reformatories were a form of 'social defence' against this danger, a means of clearing the streets of undesirables. To quote W. Byrne, who was Under-Secretary of State, at the Home Office;

> I may say now that the scum of the gutters and of the streets has been sent to these reformatories; in many instances with the

> excellent object of removing the scandal and danger and expense which their life of freedom entailed. (Official Publications 1908: q. 21)

Others described the population of inebriate reformatories in terms which went far beyond any specific concern with drunkenness. The following is from Branthwaite, the inspector of inebriate reformatories;

> . . . irreformable inebriates are persistently drunken when not in prison, commit wilful damage, attack policemen, or are publicly disorderly or indecent. They gain no benefit from repeated prison punishment; but, on the other hand, exhibit progressive physical deterioration, steady decline of mental power, and finally become hopeless mental and moral degenerates. During periods of liberty between imprisonment such persons create disturbances without number by fighting, disorderly conduct and obscene language, behaving indecently, and causing obstruction. They are responsible for assaults, wounding . . . and wilful damage. They are also the cause of considerable expense to public funds without adequate return. . . They bring into the world ill-fed, uncared-for and mentally useless children, who provide the mass from which the future criminal, drunken and lunatic army is recruited, and finally they themselves become in later years chargeable to the rates as paupers or lunatics. (Official Publications 1908: q. 209)

Just as Peddie in 1860, along with other witnesses who gave evidence to the 1872 committee, had asserted that those who could function efficiently without becoming a public nuisance were not to be considered as inebriates whatever their drinking habits, the reformers of 1908 made it clear that the criteria for inteference was social worth, as the folowing exchange makes clear.

> You would really rather take as your standard the usefulness of the man? - I would.
> If he drinks periodically, and is a useful wage earner for his family meantimes, you would not interfere with him? - Not unless he gets into trouble. (Official Publications 1908: qq. 977-8)

Overall then, it seems clear that the inebriate reformatory experiment owed little, if anything, to changes in the way of thinking about the causes of drunkenness. The concerns of the inebriate

reformatory campaigners, as manifested first in their practical proposals, and later in the way they actually selected the population for reformatories, went far beyond any concern with drunkenness. The main concern was to contain and discipline a class of persons who had not adapted their conduct and habits to new social order created by industrialization and urbanization.

CHAPTER 3

REFORMING THE INEBRIATE

INTRODUCTION

In the previous chapter I suggested that the chief functions of the inebriate reformatory were to be the containment and socialization of the inebriate and I also suggested that socialization involved installing within the inebriate the habits and values - such as sobriety, industriousness, prudence, restraint, self-help, family responsibility, thrift and accumulation - which the person had to adopt if he were to adapt to the environment created by urbanization, industrialization and capitalist production.[1] In this chapter I will try to support this argument by looking at how the reformers used the concept of treatment. I will argue that the reformers used the word 'treatment' to refer to an activity which (a) had the objective of installing these habits and values within the inebriate, thereby helping to attach the inebriety to society; and (b) employed many of the techniques of 'moral management' - moral management being a method of reforming characters which was developed, in particular, in nineteenth century lunatic asylums.[2] I will also try to show that these techniques were quite different from the activities which we conventionally think of as medical treatment.

Understanding institutional practices

Before proceeding, I will briefly describe how this analysis differs in its methodological approach, from that used in both conventional and some sociological discussions of institutional practices. These methodological arguments are important since they help us to

understand why commentators have misunderstood how terms such as treatment are used when employed in the context of quasi-penal institutions such as inebriate reformatories.

As we saw in the previous chapter, the conventional analyses of the inebriate reformatory presume that the reformatories were intended as places of medical treatment. In both of the accounts discussed it is suggested that this original aim was eventually frustated in practice. For Radzinowicz and Hood (1986: 306-10) the original medical objective was frustrated as inebriate reformatories became lumbered with incurable cases and hence became used for discipline and incapacitation. While for MacLeod (1967: 244-5), the physicalist-hereditarian perception of inebriety - which he claims was favoured by most reformers - led to inebriate reformatories being used solely for the purpose of "isolating alcoholics and insulating society". These eventual outcomes are regarded, however, as unintentional consequences; for both accounts the original objective of the reformers was to establish institutions for the medical treatment of inebriates.

That this was the original objective is presumed, rather than explicitly argued for. To be fair, Radzinowicz and Hood support this presumption with a quotation from Dr. Norman Kerr, who claimed that in cases of inebriety there was a degeneration of brain tissue, and that the confinement of inebriates in a place where they could not get any drink was therefore necessary for the purpose of facilitating the growth of "a new and ample supply of healthy brain and nerve substance" (Radzinowicz and Hood 1986: 292). However, neither

Radzinowicz and Hood, nor MacLeod, pose the question of what the reformers actualy meant by the term 'treatment'.

This reflects a more general problem with these accounts: i.e. they do not address the question of what was actually meant to happen within the inebriate reformatories. While they contain a wealth of detail about the political struggles which went on over the establishment of reformatories and over the power to confine inebriates in them, neither account tells us much about what was supposed to happen to the inebriate once they entered the reformatory. These accounts stop at the gates of the reformatory. Perhaps this reflects a more general problem in conventional scholarly discussions of institutions - and certainly of penal and welfare institutions - which often show little concern with the details of institutional practices, focussing instead, almost exclusively, upon the lofty, philosophical and political debates which take place with regard to these institutions. This in itself would not be so objectionable but for the fact that such accounts do tend to make presumptions about institutional practices and, incidentally, often make recommendations about how these practices should be altered. Hence, as we have seen, Radzinowicz and Hood (1986) and MacLeod (1967) presume that the inebriate reformatories were intended as places of medical treatment and they also presume that they eventually ended up as institutions which merely isolated and punished the inebriate.

There is, however, a long sociological tradition which does provide an alternative to purely 'external' accounts of welfare and penal institutions, the 'micro-sociological' accounts of social interaction

within institutions, as represented by Goffman's classic work *Asylums* (1961). Goffman's study is particularly pertinent here, because his analysis of institutional life is based primarily upon a participant observation study of an institution - a large mental hospital (over 7,000 inmates) in the USA - in which psychiatric discourse is a key functioning constituent, but also in which one of the primary concerns of the staff is with the control and management of the inmates. As I will argue later, the inebriate reformatory can be characterised in similar terms. Nevertheless, there are some major weaknesses in Goffman's approach which make it unsuitable for analysing the inebriate reformatory. I will briefly point out some of the specific features of Goffman's analysis, before identifying its weaknesses from my point of view.

First, to use the words of Hirst and Woolley (1982: 183), "Goffman deliberately chose to consider the institution not in terms of psychiatric rationality, its formal objectives and official organizing knowledges and practices, but instead as a specific context of social interaction". Secondly, he identified the *primary* concern of the staff as being not with treatment, but rather with the management and control of the inmates. Third, he argued that the behaviour of the inmates was interpreted in psychiatric terms; *bad* behaviour was seen as a sign of continuing illness, *co-operative* behaviour was seen as a sign of progress, and so on. Fourth, he argued that the techniques used to manage and control the inmates were also legitimated in psychiatric terms. The basic technique used was a system of rewards and punishments (early release for good - i.e. co-operative - behaviour, suspended release for bad - i.e. unco-operative -

behaviour, transfer to a more or less secure wards etc.); these were legitimated in psychiatric terms: early release was justified on grounds of the *patient's recovery*, suspended release on grounds that he was still ill, and so on.

Overall Goffman implies a clear gap between actual practice and its representation. The implication is that we cannot understand the mental institution on the basis of its official, or conventional, representation - i.e. as a domain of psychiatric rationality -, rather it is necessary to undertake a (sociological) observation of the social interaction which actually takes place within the institution.

While there is a some correspondence between Goffman's argument and that which I will make here with regard to the inebriate reformatory, there are also some important differences. In order to elaborate these differences I will point out some of the problems which I find in Goffman's work.[3]

First, Goffman's concern to study social interaction within the institution, rather than presuming that what happens can be surmised from psychiatric theory or from the public representations of psychiatric practice, is to be welcomed. There are however problems with the way in which he contrasts psychiatric rationality with asylum practice. In his eagerness "to look at the hospital with sociology in mind, not junior psychiatry" (Goffman 1961: xi), Goffman fails to realise how asylum practice *does* relate to psychiatric discourse. Because Goffman never undertakes any detailed study of psychiatric discourse, (his pre-suppositions make such analysis superfluous), he equates psychiatry with an ideal image of *medical* rationality. Since much of what happens within the mental institution cannot be properly

accounted for in terms of this ideal type of medical rationality, Goffman presumes that psychiatric discourse merely legitimates judgements and actions which take place for other reasons (management and control). The possibility that psychiatric discourse differs significantly from the ideal of medical rationality is not recognised by Goffman.

Secondly, and following from this, Goffman's contrast between psychiatric treatment and the control and management of inmates is also problematic. Goffman's argument is that the primary function of the staff is not to treat, but rather to control and manage the inmates, primarily through a system of rewards and punishments. What Goffman fails to recognise is that control and management through reward and punishment is tied to a specific theory of psychiatric treatment. Related to this, Goffman misunderstands the full implications of the control and management of inmates. The concerns with control and management do not, as Goffman suggests, derive simply from the need for order in the institution (although this is undoubtably an important consideration), rather they derive from a particular conception about what the objectives of psychiatric treatment are; a conception which is elaborated in practical psychiatric discourse and which is tied to a specific perception of mental illness. Once again the problem is that Goffman contrasts actual practice with *an ideal image of psychiatric treatment*, conceived as a form of medicine, rather than looking at how asylum practice relates to concepts of treatment which are outlined in *practical psychiatric discourse*.

Thirdly, and also related, Goffman implies that the procedure of interpreting the inmates' behaviour in psychiatric terms is illegitimate. He points out that disruptive and unco-operative behaviour is often construed by the staff as a sign of continuing mental illness. For Goffman the real problem, from the staff's point of view, is that such behaviour interferes with the smooth running of the institution. Disruptive behaviour is problematic from a moral or control point of view. The attachment of psychiatric labels to such behaviour then appears, to Goffman, to be arbitrary and extraneous (see Hirst and Woolley 1982: 187). The problem, as Hirst and Woolley point out, is that in psychiatric terms it is quite legitimate to consider disruptive and unco-operative behaviour as a sign of mental illness (ibid). Once again, the problem is that Goffman works with an ideal image of illness; his conception of illness is drawn from a crude physicalist model which, as Sedgwick points out, is hardly characteristic of the way illness is conceptualised in physical medicine, let alone in psychiatry (Sedgwick 1982: chs. 1-2).

An example of this problem, which is of particular interest to the case of inebriate reformatories, comes from Goffman's discussion of work in the mental institution. Goffman considers work solely in terms of how its meaning is affected by the context of the total institution. On the outside work is meaningful because of the financial rewards it produces (Goffman 1961: 10). In the total institution, cut off from the outside economy, there is no real incentive to work; so "the individual who was work-oriented on the outside tends to become demoralized by the work system of the total institution. An example of such demoralization is the practice of

"'bumming' or 'working someone for' a nickel or dime to spend in the canteen" (ibid: 11). Goffman argues that,

> Staff members, interpreting this begging pattern in terms of their own civilian orientation to earning, tend to see it as a symptom of mental illness and one further bit of evidence that inmates really are unwell. (Goffman 1961: 11)

The problem is that it is quite reasonable, within the terms of psychiatric discourse, to interpret begging - and more generally idleness - as a symptom of continuing mental illness.

We have already seen, in the case of the criteria for diagnosing inebriety, that idleness was central to the diagnosis of this form of 'mental abnormality'. I will argue shortly that the insistence that the inmates of reformatories work, or at least take part in 'rational recreations', was tied to a specific conception of the nature and causes of inebriety and to a specific therapetic theory. Without an investigation of psychiatric discourse it is impossible to understand the significance of work within institutions in which psychiatric discourse functions and it is impossible to fully understand the reasons why begging might be seen as a sign of continuing mental abnormality.[4]

More generally, the problem with Goffman's analysis lies in the way he conceptualises the 'gap' between the official representation of the asylum (i.e. as a domain of medical rationality) and its actual practice. Goffman's basic methodological presumption is that in order to understand asylum practice it is not sufficient to look at official accounts of what is supposed to happen, rather it is necessary to directly observe the social interaction which actually takes place

within the institution; it is necessary to focus upon 'where the action is'.

As I have suggested it is indeed necessary to examine actual institutional practices, rather than accepting official representations as accurate, if one is to understand the practice of penal/welfare/psychiatric institutions. It cannot be presumed that institutions which are represented in medical terms, in fact function according to the logic of medical rationality. The problem with Goffman is his jump to the presumption that social interaction can therefore be understood without any reference to the wider framework of assumptions, logics and objectives, within which it takes place.[5] In the context of the study of institutions, the problem is the presumption that institutional practices can be understood without any reference to the discourses which constitute them. Following Rothman (1971: xv) we might argue that where conventional accounts often fail to look behind the language of the reformers, alternative accounts, such as Goffman's, tend to ignore this language completely. I should stress that this is not an argument against 'micro-sociology' as such. The argument is not that 'wider events' are more worthy of study than 'local events'; to the contrary I have criticised conventional analyses of the inebriate reformatory experiment because they focus exclusively upon the political struggles which went on around the construction of inebriate reformatories. My argument is that we cannot understand the meaning and significance of small scale social interaction itself, without some knowledge of the wider framework within which it takes place. The problem then is the sharpness of the

distinction which Goffman draws between events inside the institution and concerns outside of it.[6]

In the following account of the inebriate reformatory I have tried to oppose two tendencies. The first is that of the conventional analyses, which presume - without looking in detail at how the concept of treatment is actually employed in the reformers' discourse - that the reformatories were intended as places of medical treatment. The second tendency which I will oppose is that which - following Goffman - would focus solely upon the control and punishment exercised by the reformatory staff, and ignore the role played by psychiatric discourse in constituting the reformatory regime. Instead of simply stating that reformatories were involved in the business of social control, I will argue that they exercised a specific form of control, and that in order to understand specific features of this style of social control (and in order to evaluate it) it is necessary to analyse reformatory practice within the context of the practical discourses which constituted it.

Overall, I will argue against the simple division between psychiatric treatment and social control, which informs both the conventional and the alternative sociological accounts of 'punitive treatment'. For the inebriety reformers there was no simple distinction between treatment and control (and nor, for that matter, between treatment and punishment). Both the conventional accounts and the alternative's such as that of Goffman, work with a 'medical model' of psychiatry, in which psychiatric intervention is totally opposed to management and discipline. I will try to show that both management and

discipline within the inebriate reformatories depended upon a specific conception of psychiatric intervention.

THE GENEALOGY OF THE INEBRIATE REFORMATORY

One implication of my methodological arguments is that in order to understand what was meant to happen *within* inebriate reformatories, it may be useful to start by looking at 'external' developments which made the idea of the inebriate reformatory conceivable. It may be useful, in other words, to look at the developments in the realm of ideas and institutional practices, which pathed the way towards the idea of inebriate reformatories, making the inebriate reformatory experiment almost the obvious path to follow. As I suggested in the previous chapter, the most appropriate developments to look at are not those realm of medical theories of alcoholism. Rather, I will place the inebriate reformatory experiment in the context of developments in institutional responses to those who were considered to be nuisances.

The 'Sober House'

The idea of the inebriate reformatory had already been in existence for at least half a century before the inebriate reformatory experiment began in Britain. In 1810 the renowned American physician and reformer, Benjamin Rush, outlined his 'Plan for an Asylum for DRUNKARDS to be called the SOBER HOUSE' (Rush 1948; emphasis in original). Rush stated:

> . . . it has occurred to several citizens that a house appropriated exclusively for persons addicted to the excessive use of ardent and fermented liquors, in which they might be reformed or accomodated where they could no longer injure themselves nor others, would be attended with the most beneficial consequences. Hitherto the hospital and the jail have been their only receptacles, but as proofs of insanity or crimes from strong drink are required for their admission into them, and as incalculable evils are often

> produced by drunkenness short of insanity and crimes, the proposed asylum would be the means of restraining and preventing them. (Rush 1948: 354-5)

In the proposed 'sober house', drunkards were to be confined in separate apartments and subjected to a definite regime,

> . . . such diet, drink and employments and means of moral and religious instruction, should be contrived for them as are calculated to promote their reformation and comfort." (Rush 1948: 355)

The problem addressed by Rush was that the existing receptacles for drunkards - the jail and the hospital - did not cater for those drunkards who, although requiring confinement, were neither insane nor criminal. It was not, however, simply that the drunkard, whom Rush had in mind, could not be sent to the jail or the hospital; the problem was also that the regime of the jail or hospital was not suitable for these drunkards. What was required was not simply another receptacle, but a '*more fitting* receptacle'.[7] The regime of the proposed sober house was to differ form that of the prison and from that of the (mental) hospital. The proposed sober house was to be neither prison, nor hospital, but something different.

Reformatories

We can further our understanding of the inebriate reformatory experiment by examining it in the context of a long history of penal-reformatory confinement of delinquents. In *Discipline and Punish*, Foucault (1977b) describes the regimes and operational principles of a number of penal-reformatory institutions. He describes the Rasphuis of Amsterdam, opened in 1596, which was originally intended for beggars or young malefactors.[8] The 'Rasphuis approach' was similar, in many respects, to that suggested by the inebriety reformers. In the

Rasphuis: (i) "the duration of penalties could, at least within certain limits, be determined by the administration itself, according to the prisoners conduct" (ibid: 121); (ii) "work was obligitary... and, for the work done, the prisoners received wages" (ibid); and (iii) "a strict timetable, a system of prohibitions and obligations, continual supervision, exhortations, religious readings, a whole complex of methods 'to draw towards good' and 'to turn away from evil' held the prisoners in its grip from day to day" (ibid).

Foucault argues that these basic principles also appeared in different ways in the blueprints of a number of other penal-reformatory institutions. He uses the examples of the *maison de force* at Ghent, the 'English model', and the Philadelphia model. The *maison de force*, presuming idleness to be the general cause of most crimes, organized penal labour around economic imperatives. Its aim was to "revive for the lazy individual a liking for labour, force him back into a system of interests in which labour would be more advantageous than laziness, form around him a small, miniature, simplified, coercive society, in which the maxim 'he who wants to live must work' would be clearly revealed" (ibid: 122). And as would be the case in the inebriate reformatory, the duration of the sentence was a subject of the utmost importance: "this reconstruction of *homo oeconomicus* excluded the use of penalties which were too short - this would prevent the acquisition of habits and skill of work - or too long - which would make any apprenticeship useless" (ibid).

The 'English model' - a term which Foucault uses to discuss the principles outlined in the works of penal reformers such as Hanway, Howard and Blackstone - added to the principle of work that of

isolation; the idea that the prisoner should work and live in solitude, or at least in silence. Originally justified in negative terms, as a way of preventing promiscuity, blackmail and escape, isolation soon became legitimated in more positive terms. It became a technique for producing moral conversion; it would provide "a 'terrible shock' which, while protecting the prisoner from bad influences, enables him to go into himself and rediscover in the depths of his conscience the voice of good" (ibid). One proponent of this "apparatus for modifying individuals" referred to it as 'a reformatory' (ibid: 123). Solitary or silent regimes did not form part of the inebriety reformers' plans, but as I will point out, the principle of isolation appeared in a modified form, as did the idea of moral conversion.

The other model discussed by Foucault is the Philadelphia model, by which he means the Walnut Street Prison, remodelled in 1790 in accordance with these new principles.[9] While this corresponded in many respects to the *maison de force* and to the English model, it also included some specific features. The prisoner's transformation was not entrusted solely to solitude, self-examination and purely religious exhortations, rather the prison administration was to continuously address itself to the task of reforming the prisoner. Connected with this, reformation was to be accompanied by "a development of knowledge of individuals" (ibid: 125). Reformation involved the use of biographical details of the offender and throughout his detention the prisoner would be observed: "a whole corpus of individualizing knowledge was being organized that took as its field of reference not so much the crime committed (at least not in isolation), but the

potentiality of danger that lies hidden in an individual and which is manifested in his observed everyday conduct" (ibid:126).

Foucault's focus in *Discipline and Punish* is on 'the birth of the prison'. Since one of the major stated concerns of the inebriety reformers was to establish an institution which would differ significantly from prisons, it is necessary to justify my *placing* of the inebriety reformatory experiment within the context of the history of prisons. In the first place, we should be sceptical about the claims made by many inebriety reformers, i.e. that their proposed institutions would differ radically from prisons. It would be more accurate to describe the blueprints of the inebriate reformatories as a modified prison regime. The proposed reformatories were to incorporate many of the features of ordinary prisons, but their regimes were to be more 'relaxed'.

There are a number of reasons why new institutions, with a more relaxed system of discipline and control, were deemed necessary for inebriates. First, the incarceration of inebriates along with 'real criminals', far from leading to their reformation, was considered to be more likely to lead to their 'moral contagion': "drunkards meet other criminals in prison and are therefore sucked into the criminal class" (Official Publications 1872: q. 150). Secondly, inebriates were difficult to manage within ordinary prisons. In his evidence to the 1872 inquiry into the problem of habitual drunkards, the prison governor H. Webster supported the inebriate reformatory experiment by arguing that "drunkards make unprofitable and disorderly prisoners. They are not fit to work the tread-wheel" (ibid: q. 139; cf. Gunn et al 1978: ch. 1). Thirdly, a more relaxed regime was considered

necessary for the incarceration of inebriates who had not committed a criminal offence (or - in the case of recidivists - who were to be committed for a longer period than would be justified by their actual offence). To send non-criminal inebriates to institutions with prison-like regimes was considered to be unjust. A milder form of discipline was the concessionary price to be paid for the extension of formal penal control to non-offenders.

My placement of the inebriate reformatary within the history of the prison appears to confirm the 'sceptical' view about the relationship between the representation and actual practice of penal institutions. It might appear that the psychiatric discourse, through which the practice of the inebriate reformatory was represented, functioned merely to throw a cloak of medical respectability over what was essentially a penal operation. It is wrong though to see the psychiatric representation of reformatory practice 'solely as an exercise in legitimation'.[10] In many ways it was quite legitimate to represent reformatory practice in psychiatric terms. The type of regime which was proposed, and which was put into practice in some reformatories, *did* in fact correspond in many respects to the ideals and practice of psychiatric treatment of the mentally deranged. The inebriate reformatory can be located within the history of the prison, but it can also be located within the history of mental institutions (even though there were important differences between asylums and inebriate reformatories). In order to appreciate this it is necessary to reject the conventional wisdom which places mental institutions and penal institutions in direct opposition to each other; the former

characterised as a domain of benign medical treatment, the latter as one of harsh discipline. While there were important differences between nineteenth century mental institutions and penal institutions, these differences are neither as great as, nor of the same nature as, conventional wisdom presumes them to be. There were in fact important similarities between the regimes of mental and penal institutions, and also between psychiatric treatment and penal techniques (cf. Rothman 1971).

I should stress however that this link between the asylum and the prison is not being made in the same terms as it is made by Goffman and by popular anti-psychiatry in general. Goffman also drew links between the asylum and the prison, but in his case the link is that both are total institutions, social organisations which differ radically from life on 'the outside' (using these criteria Goffman also places monasteries and concentration camps in the same category). Just a short step from Goffman is the more cruder and often popular, anti-psychiatry argument which links the mental hospital to the prison by arguing that mental hospitals are, in effect, prisons.'' In what follows, nineteenth century penal and mental institutions are linked in a quite different way. The link is historically specific: they shared similar regimes, with a similar, and related, set of objectives, discourses, management practices and reformatory techniques; in their blueprints, if not always in their practice (cf. Rothman 1971: particularly pp. 133 & 151). This link might best be expressed by saying that the early nineteenth century asylum, the early nineteenth century prison, and also the late nineteenth century

inebriate reformatory, were all institutions in which the discourse of moral treatment had gained a foothold.

Moral treatment was a complex system of intervention into the problem of mental disorder advocated and practised by early nineteenth century asylum managers. It differed radically, in its mode of intervention and in its underlying rationale, both from physical medicine and from physicalist forms of mental medicine. Its application was by no means limited to medical sites or to medical problems: the principles of moral treatment were applied in various forms in prisons, workhouses, reform schools etc. as a means of correcting crime, idleness and delinquency (Hirst and Woolley 1982: 181). Moral treatment could be better described - as indeed it often was - as *moral management*, since it involved the manipulation of the patient's environment, rather than technical interventions aimed directly at the patient's body or psyche. Indeed, moral treatment was more often likened to education, and to child-rearing, than to conventional medical treatment (Donnelly 1983: 44). In discourses of moral treatment the relationship between the medical-superintendent and a patient was often compared wth a parent-child relationship, rather than with a doctor-patient relationship. Moral treatment was about *character formation* rather than about healing. Based upon a conception of insanity as a defect of the *will*, moral treatment sought to teach the 'patient' how to obtain mastery over himself and to train him in habits of self-control. It aimed to transform the patient into a self-governing individual, by subjecting him to a moral and domestic environment, which the patient was to *internalise*. This intervention was premissed upon a number of related presumptions about human nature

and about the nature and causes of mental derangement. The following is a somewhat simplified summmary.

First it was presumed that all human beings had a common nature. Individual differences were presumed to derive therefore, not from nature, but from the effect of the environment - both physical and social - upon the person. It was presumed, in other words, that the person was shaped by his environment. A healthy environment would produce a healthy person, both physically and mentally; while an unhealthy environment created physical infirmity, deformity and disease, and also mental infirmity and derangement. By altering the environment one could prevent disease and infirmity, whether physical or mental. At the level of physical health this conception of the relationship between the person and his environment found expression in the public health movement. I will concentrate here upon the implications of this conception for interventions into the area of mental health, although it should be stressed that the distinction between mental and physical health was not made as sharply as it is is in much modern medical thought.

It was presumed that mental health was shaped by the environment: a *moral* environment would promote a healthy mind, while an *immoral* environment could cause mental infirmity and derangement. The term 'moral', in this context, referred, on the one hand, to the register of ethics; a moral environment was one which was virtuous in terms of 'religious' values: piety, honesty, etc. But also, and more importantly, it referred to a register of social values: a moral environment was one which was orderly, domestic, sober, industrious, clean, etc. Conversely, an immoral environment existed not only where

there was a lack of religious observance, dishonesty, etc. (the clear *signs* of immorality); it also existed where there was a lack of proper domesticity; where there was disorder, drunkenness, idleness and filth. If mental derangement was a product of an immoral environment, it followed that it could be countered through altering the person's environment, making it moral. This logic could lead to two forms of intervention. On the one hand there were those interventions which, in close association with the public health movement, aimed to alter the moral environment. Another form of intervention was to remove the person from his pathological surroundings and place him in a moral environment where he would stay until that environment had been internalised as conscience. This second mode of intervention was known as moral treatment.

Confinement was, therefore, essential to moral treatment. Confinement in an asylum was a way of containing the mentally deranged person, thereby ridding society of a danger or a nuisance. But it was also justifiable in therapeutic terms. The advocates of moral treatment saw the environment - and more specifically the family environment - as being unamenable to imposed planning or reordering, i.e. as 'unprogrammable' (see Rose 1985: 26). In order to cure the mentally dranged person it was necessary then to remove him from the family and place him in the enclosed, programmable, moral environment which was the asylum. Asylums were to be situated, ideally, in the country. Along with the fact that sites were cheaper there, rural locations meant that land was available for outdoor work. Also the tranquillity and clean air of the country would serve to counter the effects of the disorder and squalor of the city (cf. Donnelly 1983:

31-2). The asylum itself was conceived as an enclosed domain of pure morality. The patient was to be subjected to moral exhortation and taught the virtues of religious observance. But more importantly, he was to be subjected to a domesticated, industrious, and disciplined regime. Work, and in particular outdoor and domestic work, was one of the most important features of moral treatment. The regularity of labour, it was presumed, would install discipline (Donnelly 1983: 37). Discipline was also enforced through a system of rewards and punishments; the objective being not simply to maintain order within the asylum, but also to inculcate the patient with the power of self-discipline. More generally, every aspect of the asylum regime, was designed to promote order, regularity and domesticity. Patients were to work, eat, sleep, and relax, according to a set timetable; the architecture of the asylum was designed to impress a sense of regularity and neatness upon the patient (see Rothman 1971: particularly pp. 152-3; Donnelly 1983: 54-5). The esence of moral treament is captured well in the following quotation from Castel.

> Moral treatment is the manipulative technique that deduces this institution as the necessary and sufficient condition of its implementation. Its 'principles' are clearly legible in the architecture of the buildings and the arrangement of the furniture in the rooms, in the organization of groups for work and leisure, in the rigid accounting for time and the strict separation of activities, in the objective and subjective relations of subordination of patients to the medical personnel. Everything is organized there in order that reason, as complete conditioning by rules, shall annul the disorder of the spirit and morals that is madness. (Castel 1983: 258-9)

THE INEBRIATE REFORMATORY REGIME

Here I will describe how the inebriate reformatory was to operate according to those who campaigned for its establishment. I will argue

that - contrary to conventional wisdom - the inebriate reformatory was never intended primarily as a place of *medical* treatment. In place of this conventional thesis I will argue that the inebriate reformatories were conceived, from the beginning, as a places of *moral treatment* and *reformatory discipline*. I will support this argument with material drawn mainly from a number of official inquiries into the problem of habitual drunkards. These inquiries were set up as a result of the reformers' campaign. The reformers used these inquiries as an opportunity to present their ideas about the inebriates problem and reformatory treatment, as well as using them to present their reform proposals to the government and to other bodies with influence or control over penal policy.

I will start by asking what objectives the inebriate reformatory was intended to further. One thing is clear: the inebriate reformatory was meant to do far more than cure the inebriate of his craving for alcohol. When the reformers talked of curing the inebriate they had in mind a much more ambitious goal: the transformation of a ne'er'-do-well into a self-governing, productive and decent citizen (see also Branthwaite 1907-8). Also, this task of reformation was accompanied by other, familiar objectives: deterrence, containment, and retribution. The inebriety reformers saw no contradiction in pursuing these goals simultaneously; and a single aspect of the reformatory programme, such as the proposals pertaining to the work of inmates, was often seen as a means of promoting a number of objecives concurrently. Another concern of the reformers, which was expressed so frequently that it can be considered as an objective in its own right, was that of making inebriate reformatories self-financing. I will consider these

objectives separately, although I should stress that the reformers seldom drew sharp distinctions between their various objectives.

Deterrence

The reformers criticised the existing penal approach to the problem for its failure to deter the habitual drunkard (Official Publications 1872: q. 81). A number of problems were identified. First, certainty of conviction and punishment - which, as we saw in chapter one, was considered essential to a proper system of deterrent punishment - was not being achieved. A number of factors undermined 'the rule of perfect certainty'. Most important, however, was the fact that there were considerable problems in enforcing the payment of fines (by far the most common sanction) especially with regard to vagrant inebriates, so that in practice many fines went unpaid (ibid: q.1469). A second problem was that the sanctions themselves - small fines and short sentences of imprisonment - were considered inadequate for deterrent purposes. As proof that the existing system was insufficiently deterrent, the 1872 committee offered the very existence of the problem of habitual drunken offenders. The fact that "the same individual is convicted over and over again, to even more than a hundred times", proved that the existing system of sancions was neither deterring, nor reforming, the habitual drunkard (ibid: para.3).

The reformers' concern with deterrence was such that, at the very beginning of the 1872 report we find, not a reference to reformation or treatment, but a recommendation that "the laws should be made more simple, uniform, and stringent" (ibid: para.1). The reformers wanted

tougher penalties; heavier fines which would increase progressively with the number of convictions (ibid: para. 14) and, of course, longer sentences of confinement in inebriate reformatories (ibid). It was presumed that a long confinement in an inebriate reformatory, with its regime of discipline and work, would be abhorrent to the idle and undisciplined inebriate, no matter how beneficial it would actually be to the inebriate in the long term. For the inebriate from the better-off classes, mere confinement would be distasteful enough, and hence it was argued that inebriate retreats for 'gentlemen alcoholics' could operate with a more pleasant, comfortable regime (which was just as well since one would have to pay a considerable fee for 'treatment' at an inebriate retreat). The reformers also advocated the setting up of a Drunkard's Register (ibid: paras. 14-17) which would have a number of uses, but would be particularly useful in helping to keep track of a drunkard's movements, thereby easing the recovery of fines and making sanctions more certain (ibid: para. 17).

The issue of deterrence also entered the question of what size the institutions should be. Some favoured a small number of large institutions because of economies of scale. Others, such as Akroyd, preferred a large number of smaller institutions, with a maximum of fifty inmates, because of their symbolic value. The sight of the institution, as the proper place for inebriates, would be deterrent both in the direct sense, and also indirectly, due to its 'educative' value.'[12] Hence Akroyd - following the American pioneer of inebriety reformatories, Dr. Parrish - argued:

> the advantage of inebriate asylums is much wider and greater than in the mere restoration of individuals. . . . My own impression is, that if they were very numerous and not very large, scattered all through the country, the deterrent influence upon inebriates who are

> outside would be very strong. I think that institutions of this class, properly conducted, with suitable men at the head of them, would be centres of a great deal of information and light. That would go very much to formation of a proper public sentiment, and modify the estimate which people have of drunkards themselves. (Official Publications 1872: Akroyd's draft report, para. 16)

Containment

The inebriate reformatory was also advocated as a means of ridding society of a public nuisance (ibid: q. 79). As we saw in the previous chapter it was not every inebriate, but rather those who constituted a public nuisance, who were seen as requiring legal control. Aside from its reformatory and deterrent effects, detention in an inebriate reformatory would serve to remove the inebriate from 'the streets' for a considerable period. Also, the proposed drunkard's register would mark out the inebriate, thereby making his surveillance and control easier. By the time of the 1908 Departmental Committee inquiry into 'the Operation of the Law Relating to Inebriates and to their Detention in Reformatores and Retreats', containment had emerged as a major justification for the reformatories:

> . . . we consider it just and right that he [the inebriate] should be detained, not merely for his reformation, but to protect the community against his ill-doing. We are unanimouosly of the opinion that the detention of the inebriate is justifiable, and necessary, apart form all question of reformation. (Official Publications 1908: p. 18)

Reforming the inebriate

Detention in an inebriate reformatory was justified primaily as a means of reforming the inebriate. By reform was meant, not simply changing the inebriate's drinking habits, but rather a much further-reaching transformation of the inebriate into a domesticated and industrious citizen; the objective being to socialize, to civilise and

to domesticate the inebriate character. The techniques for achieving this were not those of physical medicine, nor were they physicalist forms of mental medicine; rather they were those of moral treatment and of the disciplinary techniques prefigured in the early reformatory models, which were outlined earlier in this chapter. Hence, in 1872 it was explicitly stated that "reformatories would exercise moral treatment" and "reformatory discipline" (Official Publications 1872: qq. 515-6; Akroyd para. 28). Similarly, in 1908, the objectives of the retreats and reformatories was seen as being to turn inebriates into "useful members of the community" (Official Publications 1908: p. 167). This was to be achieved through "moral suasion" (ibid: p. 168), "educational treatment" (ibid: p. 169) and discipline (ibid: p. 15, q. 736). I will now go on to describe how the reformers employed the concept of treatment, looking first at what they saw as the objectives of 'treatment'.

Self-control

One of the most frequently stated objectives was the cultivation of the inebriate's will. Throughout the proceedings of the 1872 inquiry this objective is frequently referred to: the aim of reformatory treatment would be to "strengthen and invigorate the will of the patient" (Official Publications 1872: Akroyd: para. 15); "treatment throughout, when it moves beyond mere detention, seems to take the form of restoring the moral will . . . it must restore or install a moral will so that desire can be overcome" (ibid: q. 1090); "the most perfect cure... is the acquirement of self-control (ibid: 3157); & men must be given the opportunity of "getting possession of themselves"

(ibid). Similarly, the 1908 report refers to the "instillment and cultivation of self-control" as a major objective of reformatory treatment (Official Publications 1908: pp. 5-6). These statements were based upon the presumption which we have already noted in chapter two, i.e. the presumption that the inebriate's habitual drunkenness was the product of his lack of self-control. Habitual drunkenness was just one (albeit an extremely important) manifestation of loss of mastery over oneself; inebriety was a deformation of the will.[13]

It is important to point out that what was occurring here was more complex than a straightforward shift away from a voluntarist and towards a determinist perception of habitual drunkards. We can recall from chapter one that the juridical approach to social control - and liberalism in general - presupposed that individuals posessed the capacities of free will and rationality. The reformers were now arguing that inebriates did not possess these capacities. The inebriate had little control over his own conduct; he was a slave to his desire for drink. Nor did the inebriate act rationally; he failed to calculate the consequences of his conduct with the result that this behaviour was not only a nuisance to to others, it was also self-defeating. It appears that the voluntarist-rationalist concept of human action was - at least in the case of habitual drunkards - being abandoned. However, it might be more correct to say that the voluntarist-rationalist perception of human action was being put to a different use, rather than being abandoned. Instead of presuppossing that individuals did possess free will and rationality, the reformers were using the ideal of the self-governing, rationally calculating individual as the standard by which the inebriate could be judged and

found lacking. Moreover, the same voluntarist-rationalist standard was used in order to define the objectives of 'treatment'. The objective of treatment was defined as the transformation of the inebriate from a 'determined' being into a self-governing individual. Treatment aimed to install a capacity for self-control within the inebriate. Its purpose was precisely to invest the individual with the capacities - and hence the responsibilities - of the normal self-governing, rational person. The purpose of treatment might be defined therefore as being to construct free-standing, competent individuals; the type of individual which liberalism presupposed, but did not itself account for (cf. Donnelly 1983: xi-xii).

This concern for self-control derives directly from the discourse of moral treatment and from other, associated discourses of 'management' (see Donnelly 1983: preface). For these discourses controls from within were always preferable to outward conformity to rules. Ideally, control would be achieved through the internalisation of norms, rather than through mechanical constraints or fear. This would ensure a more economic form of control in at least two respects. First it did not require constant supervision by the controlling agent. Secondly, it was a more positive form of 'control': instead of functioning simply, to prohibit certain acts, it would function positively, to make the person function in a certain way. Normalisation would not only prevent breaches of the rule, but could create in the individual the capacity and the desire to act in certain ways (cf. Foucault 1977; 1979; Donzelot 1980). This was one of the main reasons why the inebriety reformers objected to the policy which the Temperance Movement advocated at the time, i.e. prohibition of the sale of alcohol. The

inebriety reformers argued that "the acquirement of the power of self-control . . . is far better than any prohibitory laws" (Official Publications 1872: q. 3157). It had long been recognised that prohibition was inneffective, since it was easily overcome by smuggling and illegal distillation (see Official Publications 1834); it was often argued that the only effective means of promoting genuine, long-term sobriety was through 'moral means' - i.e. through education and environmental improvement - which would bring about a capability and desire for sobriety in the person. But also, as we shall see, sobriety was not the only aim of intervention. The inebriety reformers were never content to simply stop the inebriate from drinking, they also had the more positive goal of imbuing him with certain capacities and desires which were only indirectly connected with sobriety.

Industriousness

One of the methods advocated for cultivating the inebriate's capacity for self-control was making him undertake regular work: "The instillment and cultivation of self-control is necessarily an affair of time. It can only be effected by the imposition of steady work . . ." (Official Publications 1908: p.6). The imposition of work was, however, also considered valuable as a means of promoting another objective of 'reformatory treatment', i.e. the objective of transforming the inebriate from an idler into an industrious person.

As we saw in the previous chapter one of the defining characteristics of the inebriate, according to the reformers, was his idleness. Reformatory treatment corresponded to this conception of inebriety.

One of its central features was that the inebriate be made to work, in order to overcome "the habit of idleness" (Peddie 1872). The 1872 report recommended that reformatories be established on "the industrial system" (Official Publications 1872: rec'n 8). The inmate was to be made to work, preferably at useful and remunerative labour (ibid: q. 722; letter of Mr. Smith to the chairman of the committee); and the proceeds of the inmates labour "should be applied to the payment of the entire cost of maintenance while in the reformatory; if any excess remain, it should be applied to the maintenance of wife and family..." (ibid: rec'n 9).

By making the inmate work a number of objectives could be achieved simultaneously. In the first place, given the inebriate's dislike of work, forced labour would act as a deterrent. This was not, however, the main reason for the insistence that the inebriate work. Pointless and demeaning labour would probably be the most effective deterrent. Yet, the reformers insisted that work should be remunerative and useful. One of the reformers' main objections to the imprisonment of inebriates was that in prison they were given "useless hard labour", rather than being taught "trades and skills" (ibid: Smith's letter).

This concern with remunerative labour can be explained partly in terms of another objective: that the institutions be self-financing. It was constantly asserted that inebriate institutions could eventually become self-supporting. Inebriate retreats for rich dipsomaniacs would, of course, be supported by the fees of their clients. Inebriate reformatories on the other hand, were to be financed from the proceeds of the inmates labour. Despite some opinion to the contrary from those who doubted that "profitable work can be

obtained by force" (ibid: qq. 1206-7), it was confidently and constantly asserted that a enough profit could be made from the inmates labour to make the institution financially independent (ibid: rec'n 9; Akroyd's draft report, para. 17 & rec'n 6; qq. 722, 954, 2946; Peddie para. 3). Idealistic as this hope was, many nevertheless went even further in their arguments, claiming that not only could the inmate make enough to support his stay in the reformatory, but that there would be excess profit on their labour. This was to be put to two uses: First, it would go towards the support of the inmate's wife and children (ibid: rec'n 9; qq. 1524-9); and secondly, it would be saved up and given to him on his release (ibid: q. 2948-53). Thus two evils of the prison system would be thwarted. First, the inmates family would not be thrown upon the poor rates (ibid: qq. 1524-9); and secondly, the inmate would not leave the institution pennyless and hence end up in the same condition as when he entered (ibid: Smith's letter). To summarise this point in Peddie's words:

> . . . inmates might have an opportunity of earning wages, out of which a deduction should, in the first instance, be made for their own maintenance, then for the support of their families, if such there be, and the remainder go to secure additional comforts while in the institution, and to form a reserve fund for their own use after a trial of liberty is made. (Peddie 1872: para. 3)[14]

These 'purely economic' reasons, important as they were, were not the only, nor the most important reasons, for the insistence that inmates of inebriate reformatories engage in profitable labour. The most important function of labour was to turn the idle, unemployable, inebriate into a productive and industrious person. This was to be achieved in a number of ways. Most directly, the inmate would receive training in specific skills and trades, which would be useful to them

after their release (ibid: Smith's letter). It was essential then that the work undertaken in the reformatory be useful to him upon his departure; that it would enable him to earn a living.

As well as training in specific skills, there were other, less direct, reasons for the insistence that inmates of reformatories undertake profitable labour. Forced labour would perform the functions of teaching the inebriate how to work and teaching him the value of work. Its more general function was to turn idlers into "useful, industrial people" and to "teach them how to earn a living when they leave" (ibid: Akroyd para. 17.) So even those who accepted the fact that prolonged detention of inebriates would entail great expense, nevertheless supported the inebriate reformatory programme because of its "long term gains by making habitual drunkards productive, therefore saving on poor-law rates" (ibid: q. 1230).

More generally still, work was to be a means of promoting other objectives of reformatory treatment. As Foucault points out in his discussion of moral treatment, work was deemed crucial for its symbolic and disciplinary effects, as well as for its productive value.

> Work comes first in 'moral treatment' . . . In itself, work possesses a constraining power superior to all forms of physical coercion, in that the regularity of the hours, the requirements of attention, the obligation to produce a result detach the sufferer from a liberty of mind that would be fatal and engage him in a system of reponsibilities . . . Through work, man returns to the order of God's commandments; he submits his liberty to laws that are those of morality and reality . . . Foucault (1971: 247-8)[15]

Hence Peddie argued that apart from its financial value, "work itself rehabilitates" (Official Publications 1872: q. 954). Another member of the 1872 committee argued that "even profitless work would

be useful because of its therapeutic value". Even for the fee-paying patients at inebriate retreats - who could not be forced to work and didn't need to be taught skills or trades - work of some kind was deemed to be an essential: the "upper classes require occupation rather than work" (ibid: 954). Hence the provision of 'rational recreations' - and "such mechanical employment as taste and inclination may dictate and opportunity afford" - was recommended for inebriate retreats (ibid: q. 2973; see also q. 2198). One of the benefits of work was that it would facilitate the inculcation of "moral and regular habits" (ibid: q. 473). When work was mentioned it was often coupled with a concern for discipline; for one witness the essential features of the reformatory regime were "detention and forced abstinence" coupled with "rigid discipline and hard work" (ibid). But even for these purposes, *profitable* and *useful* work was to be preferred. In the first place, as at the maison de force at Ghent, this was because the objective was not simply to install a capacity for work, but also to install a desire for it. The inebriate had to be shown that work was in his interest. This was another reason for saving a portion of the inmate's income for his release. This would not only profit him directly, it would also display to him, in the most concrete of ways, the benefits of both working and saving.

Self-respect

Another reason for the concern that labour be useful was that it was also intended as a means of promoting self-respect. Once again the promotion of self-esteem was one of the main principles of moral treatment (see Foucault 1971: 248ff). With self-respect would come

self-control; the person with self-respect would restrain themselves from disgraceful behaviour because they would not wish to lose their respectability. It was argued then that "a man must have his self-respect sustained and cultivated" (Official Publications 1872: Akroyd, para. 15). One witness argued that people drink because they have lost all morality and self-respect and therefore "treatment must be long enough to restore a man's sense of worth" (ibid: q. 1990). Apart from sobriety itself, one of the main means by which self-respect was to be promoted was through work. Hence the need for useful and profitable labour; self-respect would be obtained when the inmate felt that he was a contributor to, rather than a burden on, society - when he felt that he was worth something. Hence Peddie argued the need for "useful and remunerative labour of various kinds" in the following terms.

> No better counteractive to the tendency to intemperance can be employed, none better fitted to generate feelings of self-esteem, and gradually strengthen the power of self-control, than occupation and the steady cultivation of industrial habits, especially with the stimulus of obtaining some immediate as well as ultimate advantages from the same. (Peddie 1872: para. IV)

Domestication

As I have already mentioned, female inebriates were to be taught domestic skills. It was suggested that women be educated under the industrial school system "so that they will make good wives" and trained to "make working class homes comfortable and habitable" (Official Publications 1872: q. 831). This training in domestic skills also included 'instruction' in "the rules of hygiene" (ibid: q. 2967). On this issue, the inebriety reform movement intersected with a much broader movement which had as its objective the domestication of the residuum. Beyond the concern with individual inebriates, the inebriate

reformatory was seen here as a means of spreading the norm of domesticity, through the training of women from the bottom sections of the working-class women in domestic habits.'[6]

The objectives of promoting domestication and self-respect were also linked: "sanitary and hygienic measures" were a means of promoting "self-respect and self-control" (ibid: q. 2974). The domesticated woman would take pride in her home and so acquire self-respect. This interlinking of the themes of domestication and self-respect comes across in the following quotation form Lady Somerset, who ran an inebriate reformatory at Duxhurst.

> I have taken great pains in the cottages at Duxhurst to see that they have only such surroundings and such things as they would have in their own homes if they were living as self-respecting citizens under conditions such as they ought to have. I think it is a help to them when they go out to have lived in homes conducted in this way and to realise that that is what their own homes must be. (Official Publications 1908: q. 1092)

Managing the inebriate

I will now go on to look at the 'techniques' which were to be used for bringing about these objectives. Some of these have already been covered in my discussion of the role of work within the inebriate reformatory regime. I will concentrate, therefore, upon the other methods of 'mangaging the inebriate' which were advocated. By and large, these corresponded to the methods of moral treatment which had been elaborated by lunacy reformers in the first half of the nineteenth century. The inebriate reformatory regime was also prefigured by the reformatory models described by Foucault in *'Discipline and Punish'*.

Altering the inebriate's environment

The reformers regarded confinement as an essential ingredient of reformative treatment. Confinement was regarded as necessary, in the first place, as a means of removing the inebriate from the associations and surroundings which contributed to his inebriate life-style. Through confinement the inebriate "is withdrawn from the associations that he has been accustomed to, from the temptation with which he has been surrounded in society, and in that respect is able to come to himself" (Official Publications 1872: q. 2607). This justification for confinement clearly depends upon an analysis of inebriety as a problem which is caused, to a considerable extent, by a bad 'environment'. In this context, the term 'environment' would include both the physical environment and the 'social milieu', e.g. the company which the inebriate kept. It appears to have been presumed that the inebriate was, to a considerable degree, the 'product of his environment'. Hence in order to change the inebriate's character, it was necessary to alter his environment. The environment, however, appears to have been regarded as fixed and unalterable (at least in the short term). Altering the inebriate's environment therefore meant removing the inebriate from his environment. It involved:

> ". . . breaking up former habits and associations, drawing from the mind those old companions of an intemperate life, forming new thoughts, new ideas, and new and better habits, necessitating a new life in every respect; a radical change.
> (Official Publications 1872: q. 2974)

Hence treatment would work better with younger inebriates, who might not yet have been fully integrated into a bad environment and were therefore easier to remove from it: "I think the younger you can get hold of these people the less likelihood you will find of their going

back again" (Official Publications 1908: q. 569). Also, in order to be successful, reformatory treatment should preferably be followed by the placement of the inebriate in a different environment from that which he, or she, had come from.

> I do not know whether any assistance is given to them to start life afresh in some other neighbourhood and give them an opportunity of that kind, I think it would be very useful, but at present, if they have no means, they must go back to the district in which they formerly lived, . . . if they come back to their old neighbourhood I think their fate is sealed. (Official Publications 1908: qq. 1148-9)

In addition, if the aim was to remove the inebriate from her environment, one had to be careful not to 'import' that environment into the reformatory by sending inebriates from the same area to a single institution.

> I think one of the worst features of the present character of reformatories is that the women of the same locality go mainly to the same reformatory . . . when you get a woman sober and anxious to lead a better life an old companion who had known her perhaps in the same doss-house in London, and knew all about her former life, came down, and this woman would laugh at the idea of her companion's reformation, and would undo in a few days what we had been trying to build up for many weeks . . . I would send the women as far from their own locality as possible, and I would keep as few women as possible from the same districts together.
> (Official Publications 1908: qq. 1090-1)

This analysis of inebriety was somewhat different then to the physicalist theories of inebriety and dipsomania which were being debated at the time. And importantly, this environmentalist analysis of inebriety had different implications for 'treatment' than did physicalist analyses. Whereas physicalist analyses would imply that physicalist treatment was the most appropriate response to the problem, the environmentalist analysis implied a 'social' model of treatment. What was required was not so much an alteration of the

offenders physical make-up, but an alteration of the offenders environment.

However, the purpose of confinement was not simply to remove the inebriate from an bad environment, rather it was to place the inebriate in a better - or a more 'moral' - environment. In such an environment the inebriate could learn how to conduct himself and would internalise a set of attitudes about correct living. The inebriety reformers therefore discussed the details of the architecture and the regime of refomatories in detail. It is necessary to pay attention to these discussions since questions about reformatory architecture and regime were not incidental or 'purely administrative matters', rather they were of the utmost importance because the regime was, in a sense, the essence of reformatory treatment. In analysing reformatory treatment it is wrong to separate questions of 'correct architecture' and 'good administration' from questions of therapy, because therapy consisted precisely of placing the offender in a properly designed, properly run, institution. This point may become clearer as I discuss the various aspects of the reformatory regime.

Architecture

Reformatory treatment was to operate by altering "the whole atmosphere surrounding the patient" (Official Publications 1908: q. 741). To this end, the reformers paid a lot of attention to the issue of the 'mood' which buildings could evoke. Hence the architect of a women's reformatory in Lancashire was directed to "prepare a scheme in which light, air, and pleasant surroundings should be considered as necessary concomitants to the reformatory" (ibid: q. 1565). The

reformers took great pride in those reformatories which were "extremely well built, light and airy and clean, and built in a manner which will reduce the cost of repairs and maintenance considerable" (ibid: q. 1677). Such reformatories would be a direct contrast to the homes of inebriates which, as we saw in the previous chapter, were criticised by the reformers as unpleasant, ill-kept and squalid.[17]

Regularity and order

Regularity and order were to be key key features of reformatory discipline. They were regarded as the antidote to the irregularity and indiscipline of a drunken and idle life. Moral and regular habits would result from living according to a strict set of rules and a strict timetable: "prompt attendance at meals and upon religious exercises; retirement at ten o'clock in the evening and lights to be extinguished at half-past-ten; no spiritious or fermented liquors to be used, and indulgence in tobacco disapproved" (ibid: Akroyd, para. 20). The set timetable played an important role in reformatory treatment. This can be seen by the frequency with which the reformers described the routine of reformatories. One reformer, for example, in describing an inebriate reformatory under the mangement of the Lancashire Inebriate (Act) Board, told the Select Committee of 1908 that;

> The daily routine, which illustrates the policy of the house, may be of some interest:
> Rise at 6.30 a.m.; morning prayers 7.15; breakfast 7.30 to 8 a.m.; work 8 - 12.30 p.m.; dinner 12.30 - 1.30 p.m.; work 1.30 to 5 p.m.; tea 5 to 5.30; exercise and recreation 5.30 - 8.30; supper 8.35; prayers 8.50; retire 9 p.m.; all lights out 9.30.
> (Official Publications 1908: p. 170)

It needs to be stressed that this timetable was advocated not just as a means of maintaining discipline within the reformatory, thereby making the reformatory easy to manage, rather it was also seen as a technique of reformatory treatment. Treatment involved 'training' the inebriate to live his, or her, life according to an established and orderly routine. The inebriate was to be 'taught' "unswerving discipline" (ibid).

Rewards and punishments

Another key element in reformartory discipline was the imposition of a system of rewards and punishments. Good behaviour was to be rewarded with privileges. The system in American inebriate retreats, whereby patients who obeyed the rules for eight weeks were allowed to visit the nearby city twice a week, was recommended. Apart from encouraging conformity, this could also be used to test the extent of the patient's recovery; if he returned sober after limited exposure to the temptations of freedom, then he could be considered on the road to recovery (ibid: Akroyd, para. 20). The use of a system of privileges would help prevent breaches of the rules and be used to test the patient's self-control. But even more importantly, it would encourage inmates to strive to improve themselves; it would act positively, to promote norms, as well as negatively, to ensure conformity. Hence Peddie advocated a system of "rewards and benefits immediately derivable from industry and good behaviour" (Peddie 1872: para. IV). And, the superintendent of an American inebriate retreat, which was seen as a model for reformatories in Britain, stated:

> When a patient has been with us three or four months, has been obedient to all the rules, and is what we call an excellent model patient, I grant him other priveleges, and do not restrict him to

going out twice a week. (Official Publications 1872: q. 2975)

Breaches of the rules were to be punished by withdrawal of privileges (ibid: Akroyd, para. 20). Other methods of punishment included the imposition of fines (another reason for remunerative labour) and "limiting particular creature comforts, and withholding certain pleasures" (Peddie 1872: para. IV). The effects of such a system of rewards and punishments is well described by Foucault. It allows an intensification of control, whereby every aspect of behaviour is judged and sanctioned, and therefore subject to manipulation: it creates a positive, rather than a purely negative, form of intervention.

> . . . instead of the simple division of prohibition, as practiced in penal justice, we have a distribution between a positive pole and a negative pole; all behaviour falls in the field between good and bad marks. (Foucault 1977b: 180, see also pp. 180-83).

The semi-determinate sentence and 'licenced freedom'

The possibility of an effective system of rewards and punishments would, of course, be greatly enhanced if the reformatory administration had control over the length of the inmates sentence. As we saw in chapter one, the juridical approach to social control favours a determinate sentence. One of the central aims of the refomatory movement on the other hand, as Foucault shows, has been to give the administration the power to adjust the sentence, according to the inmate's conduct. The inebriate reformatory campaigners were no exception: they argued that "no definite period can be given of how long a cure will take" (ibid: q. 709) and therefore the "superintendent should exercise his own judgement as to the release of the dipsomaniac" (ibid: q. 481). One witness stated that,

> the proposition which is lying at the back of this committee (is) the establishement of institutions in which a person can be... kept and treated for such a length of time as *in the judgement of those in charge of him* will be sufficient to effect his cure. (Official Publications 1872: q.473, emphasis added)

As these statements show, the need for such a power was often represented through a medical analogy: just as the length of a hospital stay is decided according to the treatment needs of the patient, so the inebriate should not be released until he is cured. However, elsewhere in the proceedings of the 1872 inquiry, it is possible to find administrative control of the sentence being justified in somewhat different terms. First, as we have just seen, this flexibility could be used as a means of controlling the inmate's behaviour. Secondly, it could be used as a means of strengthening and testing the inmate's self-control.

In order to explain this second argument it is necessary to look at the actual proposals regarding the length of the inebriate's detention. The reformers did not ask for a totally indeterminate sentence. This was partly due to a tactical compromise. Proposals for an indeterminate sentence would almost certainly have attracted the opposition of liberals, who regarded the indeterminate sentence as an unacceptable affront to liberal-juridical principles.[18] The policy which the reformers pursued - i.e. semi-determinate sentencing - was not altogether uncontroversial, but was likely to meet with less opposition. But along with being wise from a tactical point of view, the semi-determinate sentence was also, in many respects, preferable to the indeterminate sentence. In order to explain this I will outline the reformers' proposals in more detail.

The committee asked for was a sentence of not less than three nor more than twelve months (ibid: rec'n. 4).[19] After serving the minimum period, the inebriate would then be eligible for release on licence; depending, of course, upon his conduct. This placed considerable discretion in the hands of the reformatory administration. This discretion was represented though, as being exercisable only in the direction of leniency. The administration would only have the power to reduce, but not to increase, the (judicially determined) sentence: "The period of detention should be fixed by the court of inquiry, or by the magistrates, but may be curtailed upon sufficient proof being given that a cure of the patient has taken place (ibid: rec'n. 6).

This was not simply a ploy to get longer sentences; the reformers fully intended this power of early release to be used. Apart from its disciplinary uses, its benefit was that it opened up the possibility of a new mode of intervention. In between the options of detention or total freedom, this 'parole period' created a third possibility: a licenced and supervised freedom. The inebriate's self-control could then be tested by seeing how he coped with this supervised freedom. If he relapsed he could be returned to the reformatory: if he remained sober for a considerable period then it his treatment could be deemed successful. Not until the patient has "regained the power of self-control under temptation, and that self-control has been fairly tested, should the patient be considered cured" (ibid: Akroyd: para. 11; see also Peddie 1872: para. IX). But the parole period could also be used as a means of strengthening the inebriate's self-control; i.e. it would be part of the 'treatment'. During his parole period the inebriate would have full freedom of movement, but at the same time he

would be aware that he was being observed. This gave him the chance to *gradually* adapt to the temptations of freedom, thereby gradually increasing his powers of self-control. Hence, the parole period was justified by one witness as being for the purpose of enabling the inmate to resist temptation and acquire self-control: "he should go where the temptation is" (ibid: q.2761).

Inebriate retreats

So far, I have been concerned mainly with inebriate reformatories. The reformers were also concerned with the establishment of inebriate retreats for fee-paying clients who entered voluntarily. In these retreats, for obvious reasons, the 'harsher' techniques of reformatory discipline could not be employed. Whereas reformatories would ideally be separate institutions but could be attached to prisons or workhouses (q. 649, 669), inebriate retreats were to be established in rural districts and were to employ some of the milder methods of moral treatment:

> . . . sanitary and hygienic measures: restraint from business and the busy scenes of everyday life; quiet, reading, writing, pure air, well-ventilated rooms, good-nourishing diet, regular hours for meals, rising and retiring, proper physical exercise.
> (Official Publications 1872: 2973)

What should be recognized though is that the same concept of treatment informed the blueprints for the inebriate retreat and the inebriate reformatory. The reformers seldom saw it necessary to state whether they were referring to retreats or reformatories, except when they were talking about admission, financing, work of inmates etc. Treatment in both the reformatory and the retreat depended upon the same concept of management; which received a different emphasis

depending upon the population which was to be subject to it. Rich, fee-paying dipsomaniacs would be dealt with through the milder techniques; poor, 'criminal' inebriates were to be subjected to some of the harsher techniques of reformatory discipline. The conception of the problem in both cases was similar, the objectives of intervention were also the same.

Medical treatment

Finally, a word about the place which medical treatment was to have in the inebriate reformatory. The reformers drew a distinction between medical treatment on the one hand (by which they generally meant physical treatments), and, on the other, the moral treatment or reformatory discipline which was to be the main form of 'treatment' used. Medical treatment was to play a rather limited role in 'rehabilitating' the inebriate. There was certainly no 'cure' for inebriety in the strictly medical sense, no technical intervention or drug which could cure the habitual drunkard of his condition. Only the steady inculcation of moral and regular habits was of any value. Not everyone agreed with the reformers on this. There was those who claimed to be "in possession of a specific remedy for the cure of drunkenness"; but these were dismissed by the reformers as "quacks" (ibid: q. 2974).[20] This is not to say that there was to be no medical treatment (in the strict sense) at the inebriate reformatory; but such treatment was to play a minor role, facilitating 'treatment', rather than being the treatment itself. Medical treatment was to be used, for the most part, during the first few days of confinement. Its role was to mitigate the physical effects of alcohol consumption and sudden

withdrawal, in order to get the inebriate into a physical condition in which he could undergo moral treatment.

> Nearly all patients on their admission require medical treatment; stimulant, sedative and narcotic remedies are usually administered at the outset, followed by alternative medicines to improve and correct the secretions, after which tonics, both vegetable and mineral, are given, calculated to add tone and strength to the system. When we have organic diseases, appropriate remedies adapted to each particular case are administered to relieve and assist nature in removing the same. Outside of these functional and organic difficulties very little medical treatment is demanded or required..." (Official Publications 1872: q. 2973)

THE PERCEPTION OF INEBRIETY

Finally, in this last section I will examine the perception of inebriety which informed the inebriety reformers. I will argue (a) that the reformers' perception of inebriety cannot be properly characterised as determinist; and (b) nor can it be characterised as specifically medical.

Responsibility

I will look first at whether inebriety was seen as a determined condition. At first, it seems that inebriety was regarded as a determined state. Consider, for instance, the following description of the inebriate, which is from the 1908 Departmental Committee.

> His drunkenness, and the condition of mind consequent on oft-repeated drunkenness, cannot be considered to nearly the same extent the result of his own voluntary action. In his case the desire for drink is so overmastering, self-control is so inadequate, and in many cases the ill affects of drink are so imperfectly appreciated, that it cannot be proper to hold the inebriate offender fully responsible. (Official Publications 1908: p. 15)

Many similar quotations can be found. It seems, therefore, that there was a straightforward shift towards a determinist view of habitual drunkenness in this period. If we look closer at the

inebriate reformatory experiment, however - and if we look in particular at the concept of treatment which it employed - it becomes clear that the situation was, in fact, more complex.

First, if we return to the arguments about the inebriates lack of control over his habit, we often find that they are addressed to a specific issue, the issue of the inebriate's *legal responsibility*. The reformers were concerned to argue that inebriates should not be categorised along with ordinary offenders, as fully responsible for their actions, and as therefore subject to intervention only if they had transgressed the law. The reformers wished to exclude inebriates from the full protection of liberal-juridical guarantees against unwarranted interference with personal liberty. They therefore argued that inebriates, unlike ordinary delinquents, were not fully responsible for their actions.

In other circumstances, however, the inebriate was clearly considered to be responsible both for his condition and for its 'cure'. Inebriety was characterised as a disorder of the will, as a failure to exercise self-control. The inebriate's will was weak and therefore he could not resist bad habits, whether these involved drunkenness or other indulgences (abhorrence of steady employment, excessive sexual indulgence, violent temper, etc. - see ibid: p. 6). But the inebriate's will was weakened in the first place, by the habitual indulgence in these vices. Moreover, the will could be restored or strenghthened by voluntary effort, by abstaining from vice - adopting more moral habits, by undertaking steady employment etc.

But there are cogent reasons why the term disease should not be used to characterise the inebriate habit. By disease is popularly

> understood a state of things for which the diseased person is not responsible, which he cannot alter except by the use of remedies from without, whose action is obscure, and cannot be influenced by exertions of his own. But if, as is unquestionably true, inebriety can be induced by cultivation; if the desire for drink can be increased by indulgence, and self-control diminished by lack of exercise; it is manifest that the reverse effects can be produced by voluntary effort; and that desire for drink may be diminished by abstinence, and self-control, like any other faculty can be strengthened by exercise. It is erroneous and disasterous to inculcate the doctrine that inebriety, once established, is to be accepted with fatalistic resignation, and that the inebriate is not to be encouraged to make any effort to mend his ways. It is more so, since inebriety is in many cases recovered from, in many diminised, and since the cases which recover or amend are those in which the inebriate himself desires and strives for recovery.
> (Official Publications 1908: pp. 5-6)

Heredity and environment

If inebriates were indeed regarded as responsible for their condition then it might be thought that the heredity versus environment debate was redundant. This debate seems to presume that inebriety is determined, the question being, by what. But, to the contrary, proponents of heredity and environmentalist theories managed to harmonize their ideas about the inebriate's responsibility for his condition with theories about the causality of inebriety (cf. Nye 1984: ch. 4). The way in which this harmonization was achieved will be examined later in the thesis, when I look at the category of 'moral insanity'. My concern here is to argue (a) that the treatment of inebriate's presupposed an environmentalist theory of inebriety, and (b) that this was not necessarily at odds with an heredity theory of inebriety.

First, although the reformers often asserted that inebriety was an inherited condition (the actual argument was more often that a suscepibility to inebriety could be inherited) they never developed

any techniques for dealing with inebriety as an inherited, physical condition. As Macleod (1967) points out, in the absence of such techniques, the heredity theory of inebriety could only lead to therapeutic pessimism. All that could be achieved was the isolation of the inebriate, both in order to prevent his being a public nuisance and in order to prevent him, or her, from producing offspring who would also be inebriates. Macleod is wrong, however, when he states that the inebriety reformers were in fact pessimistic about the treatability of inebriety. As I have argued, the inebriety reformers clearly regarded inebriety as a treatable condition. Treatment was directed, however, at the environmental causes of inebriety. The whole emphasis of reformatory treatment was upon altering the inebriate's environment - removing him from a bad environment and placing him in a moral environment which would then be internalised as conscience. The question of heredity versus environment, whatever its philosophical interest, was therefore of little practical importance. In practice, the physical causes of inebriety could not be treated, while the environmental causes were treatable.

CHAPTER 4

REHABILITATING THE VAGRANT ALCOHOLIC

The 'Treatment' of Habitual Drunkards in the 1960s & 1970s

INTRODUCTION

My analysis of the inebriate reformatory experiment suggests that the increasing use of medical terminology in penal discourses does not necessarily mean that there was a shift from a juridical to a medical approach to social control. I have argued that in the case of the inebriate reformatory experiment the use of a medical vocabulary was associated with a more complex and subtle transformation in the way a social problem was perceived and managed. It could be the case, however, that a shift towards a medical approach to social control occurred much later. Hence, in the 1960s there was a fresh attempt to replace the penal approach to the problem of habitual drunkards with a treatment approach.[1] Once again, it has been presumed that what was occurring was a shift towards a medical approach to the problem. Such presumptions are not without foundation, since the new treatment programme was often represented through medical language and metaphor. It was argued for instance, that the treatment policy represented the imminent triumph of medical rationality over conservatism, as science and humanitarianism rescued the alcoholic from the domain of moral condemnation and punishment.

> Informed opinion is today prepared to accept that intoxication and alcoholism are not to be regarded as crimes to be punished, so much as diseases to be cured if possible. In the field of alcoholism we are witnessing the same transition as we saw, not so long ago, in the field of mental illness; the alcoholic is moving away from the position of social outcast to the position of ordinary patient who can and should receive treatment. Even our criminal law, so often the last refuge of conservatism, has at last taken a timid step along the road to progress. But with our prisons still containing a

> substantial portion of men and women whose predominant problem is alcoholism, it is clear that we have not travelled nearly far enough. (Silkin 1969)

In this chapter I will argue that this use of medical terminology was, once again, associated with a transformation which was more complex and subtle than a simple shift towards a medical approach to social control. I will suggest that the shift which occurred was towards a social-psychological approach to the control of habitual drunkards. I will also suggest that while there were substantial differences in detail, this social-psychological approach to social control embodied a similar set of assumptions, logics and objectives to those which informed the inebriate reformatory experiment.

VAGRANCY, ALCOHOLISM AND SOCIAL CONTROL

The arguments of this chapter can be clarified by comparing them with the account of the treatment programme presented by Peter Archard in his book *Vagrancy, Alcoholism and Social Control* (1979). I will suggest that, despite its many merits, Archard's account fails to grasp the meaning of the treatment programme.

Archard identifies four strategies which have been "devised to control the derelict alcoholic": moral, penal, medical and social (see figure 1). He argues that the penal and moral forms of control were dominant from Victorian times to present, but that they are now tending to be replaced by a socio-medical approach: "a socio-medical approach to the problem is tending to replace concepts of moral reform and legal control (ibid: ch. 1). Or as he puts it later: "Medicine and social work, in combination, are tending to assume dominance,

Dominant Ideological base	Dominant View of Skid Row Alcoholic	Main Strategy of Recovery	Institutional Base
Moral	Spiritually Weak	Salvation	Missions
Penal	An Offender	Correction	Police Cells, Courts, Prison
Medical	Diseased	Treatment	Alcoholism Units (Detoxification Centres)
Social	Socially Inadequate	Rehabilitation	Shop-fronts, Crypts, Half-way Houses

Figure 1, Skid Row Social Control Matrix (from Archard 1979: 14)

theoretically and in the formulation of policy, over moral and penal approaches" (ibid). This thesis does not, however, fit well with Archard's descriptions of the network of agencies through which the habitual drunkard is controlled; it is therefore modified in a number of ways. It is argued, for instance, that we are in a period of transition in which the penal and moral approaches have not been totally displaced, therefore - "at present the institutional structure on skid row offers *simultaneously* moral, legal, medical, and social approaches" (ibid: emphasis in original). Elsewhere in the book, Archard argues that administrative and political concerns have led to medicine and social work being "grafted onto" rather than replacing penal/moral institutions.

A major problem with Archard's analysis is the way in which he opposes traditional penal and moral approaches with the modern therapeutic approach. I will attempt to demonstrate throughout this chapter that, while the treatment programme did differ from

traditional moral/penal approaches, the differences were neither as sharp as, nor of the same nature as, Archard presumes them to be. The treatment programme - whether considered from the perspective of its 'dominant view of the skid row alcoholic', its 'strategy of recovery', or its 'institutional base' - was, in many respects, continuous with traditional moral/penal approaches to the problem of habitual drunkards. What is at issue here is the adequacy of Archard's conceptual framework - and especially of the opposition he constructs between moral/penal and social/medical approaches - for understanding changes in the social control of habitual drunkards.

As I have suggested, Archard does in fact struggle with this conceptual framework; his observations often contradict it. He finds that the simple ideal types he constructed - moral, penal, medical and social approaches - are in fact totally confused in practice. We have just seen some of the ways in which Archard attempts to modify his thesis. Later in the book, Archard is even more uncertain, as when he argues that - "At best, a treatment rationale has only been theoretically introduced into the penal system as justification for the continuing legal processing of alcoholics" (ibid: ch.5). Similarly, he states that "the shift from penal to socio-medical control of homeless alcoholics", has been achieved, not in practice, but only "at an ideological level" (ibid: ch. 7). This presents Archard with a conundrum: "why is it that in spite of this ideological shift, the vast majority of alcoholics continue in practice to be handled by the law" (ibid). This problem becomes particularly acute when Archard describes the implementation of the 'socio-medical model'. He notes that all the approaches he identifies, not only exist together, but

are in fact mingled: agencies based upon Christian charity are defined as part of the treatment system; the human sciences are used to fortify moral standpoints; and Christian based agencies employ social workers, doctors and psychiatrists. Rather than revising his thesis in the light of this evidence, Archard dismissively explains all this as the product of conceptual and practical confusion: the complexity of the "punishment and treatment matrix is the product of conceptual and practical confusion about whether the habitual drunken offender should be defined as spiritually weak, criminally deviant, mentally sick, or socially inadequate" (ibid: ch. 1).

A second problem with Archard's conceptual framework concerns the way he views the relationship between medicine and social work. As we have seen, Archard identifies these as seperate approaches, each with its own conception of the problem, strategy of recovery, and institutional base. He then has to account for their collaboration to form a hybrid 'socio-medical approach". Archard does this by arguing that each selects different aspects of the skid row man for consideration and modification (ibid). The skid row man presents two problems: his vagrancy and his drinking - he is a vagrant alcoholic. Medical experts, he argues, address the problem of the skid row man's alcoholism, *conceived as a chemical dependence upon alcohol*; their task is therefore to provide *treatment* for alcoholism. Social workers, he argues, address the problem of the habitual drunkard's social isolation and social inadequacy; their task is that of social rehabilitation. This thesis has the merit of recognising that social rehabilitation is a major ojective of modern interventions into the problem of habitual drunken offenders and also of recognising that

social rehabilitation is not necesarily a medical objective. The problem with the thesis is the role it ascribes to medicine in the overall strategy of intervention into the problem of habitual drunkards and, most importantly, the presumption that 'treatment' is a purely medical concern which is directed solely at the habitual drunkard's alcoholism, and not at his social inadequacy. In Archard's book, 'treatment' refers to *medical treatment* which, for him, is something quite distinct from social work's strategy of *social rehabilitation.*

The source of the problem is revealed when Archard writes about the "collaboration of medicine (psychiatry) and social work" (ibid: ch. 1). The problem here is the unargued 'jump' from medicine to psychiatry. Throughout the book Archard uses the terms 'medicine' and 'psychiatry' as if they were interchangeable.[2] In doing so, he implicitly accepts the conventional description of modern psychiatry, as a branch of medicine which specializes in mental illness. According to this description, psychiatry approaches mental illness through the medical model; it looks for the underlying disorder of the brain or psyche which causes mental illness and tries to eliminate this underlying disorder either through physical treatments, or through non-physical therapies which are based upon principles similar to those of physical treatment. According to the medical model, such treatment typically takes place in a mental hospital.

The contemporary psychiatric system

As a number of writers have pointed out, such descriptions fail to grasp the nature of the contemporary psychiatric system. Most notable

here, is the recent work of Miller and Rose (Miller and Rose 1986; Miller 1986; Rose 1986). While not denying that some psychiatry does conform, more or less, to this conventional description, they argue that the most important developments in the psychiatric system - during the twentieth century - have taken place beyond the confines of the medical model and medical institutions. The twentieth century, they argue, has witnessed the birth of a *social psychiatry* which differs radically - in the problems which it addresses, in its mode of intervention, and in its institutional bases - from 'medical psychiatry'. The birth and development of social psychiatry has altered, fundamentally, the nature and the contours of the psychiatric system.

The psychiatric system no longer confines itself to intervention into the problem of mental illness, in the restricted sense of the term (i.e. the gross mental disorders which used to be called madness). Psychiatry now intervenes into a whole range of "less severe forms of behavioural disturbances and personal distress" (Miller 1986: 14). It is now concerned with minor and remediable behavioural and emotional disturbances which cause social inefficiency and personal unhappiness. Psychiatric interventions are not confined to physicalist methods of treatment, such as the use of drugs, electro-convulsive therapy, or psycho-surgery. Nor is the balance made up of conventional psychoanalytic therapies - despite the undoubtably significant role psychoanalysis has played in the re-shaping of twentieth century psychiatry. The most significant interventions offered by the contemporary psychiatric system owe little to organicist medicine and are only indirectly related to psychoanalysis. They consist of social

therapies, behaviour therapies, and other 'therapies of normality'.[3] Implicit in the use of such therapies is the presumption that social factors are the predominant cause of these disorders. The existence of organically caused mental defects is not, however, denied; to the contrary one of the roles of psychiatric diagnosis in contemporary psychiatric treatment programmes is to divert those whose disorder *is* organically caused away from the programme (see Rose 1986: 79-80).

Correspondingly, the modern psychiatric system is not confined to the mental hospital; it extends far beyond the world of institutional confinement. Psychiatry operates wherever mental distress, behavioural problems or social inefficiency become interpreted and constituted as psychiatric problems: e.g. the family, school, community, the judicial system and industry (Miller 1986: 39). It operates through other institutions, such as the prison (see Carlen 1986). Psychiatrists are employed by institutions such as these, not simply to carry out psychiatric diagnosis and treatment, but also to advise administrators on how to run the institution in a way which will minimize mental disorder and behavioural problems and which will promote mental health. Hence psychiatry operates by shaping other institutions and practices according to psychiatric criteria. It operates therefore, not just through the psychiatrists, but through other agents: penal administators, social workers, parents, teachers etc.

To say that psychiatry has become involved in the problem of habitual drunkards is by no means tantamount, then, to saying that the problem has become medicalized. I will argue that it is from the direction of social psychiatry that psychiatric interventions into the problem of habitual drunken offenders have come. If this is correct,

then it is misleading to characterise those interventions as medical in the way Archard does. This has some important consequences for his thesis. First, the collaboration between psychiatry and social work is a far more complex affair than it appears in Archard's account. For Archard, psychiatry handles the medical aspect of the problem, while social work deals with the social aspect. As we have just seen though, psychiatry is as much involved in the social terrain as is social work. We have also seen that psychiatry operates, partly, through social work. Psychiatry and social work are already heavily involved in a complex relationhip; they should not be thought of as entirely different processes that occasionally work together.[4] A second consequence is that once the 'medical' is left out of the picture - and I will argue that it must be - then there can be no simple opposition between traditional moral/penal approaches and contemporary treatment. If treatment is understood not as medical treatment but as social rehabilitation, then it can no longer be conceived as directly opposed to traditional moral/penal approaches. Traditional moral/penal agencies and techniques might form part of the rehabilitation system.

THE 'REDISCOVERY' OF THE HABITUAL DRUNKARDS PROBLEM

Proponents of the treatment policy often suggested that the campaign to replace the penal processing of habitual drunkards with a treatment approach was founded upon the realisation that 'alcoholism' was an illness, similar to mental illness: since the majority of habitual drunken offenders were clearly alcoholics, it followed that they should be treated rather than punished as if they were criminals. In opposition to such reasoning, critics - such as T. Szasz (1972) -

argue that 'alcoholism' is not an illness, that habitual drunkenness is simply a bad habit. This criticism is directed at 'the disease concept of alcoholism'.[5] When it comes to understanding the treatment programme, however, such attacks on the disease concept of alcoholism are of little value. The suggestion that there was a simple transfer of the problem of habitual drunkards from a moral-penal register to a medical register is misleading. The emergence of the treatment programme followed a much more complex path.

In his book *Vagrant Alcoholics*, Tim Cook (1975) traces the origins of the Alcoholics Recovery Project, a voluntary organization which played a large role in promoting awareness of the habitual drunkards problem and in establishing the treatment programme. In doing so he makes it clear that the habitual drunkard owed his rediscovery to the fact that he was a public nuisance. Cook traces the origins of the project to concern among the residents of the south London borough of Southwark, about the problems caused by vagrant alcoholics congregating and sleeping rough in the area. The initial concern was about the problem caused *to* the local residents (i.e. the 'settled' residents) by the existence of vagrant alcoholics: "A local newspaper (*Mercury*, 1 October 1965) described Southwark as 'one of the worst hit boroughs by 'down-and-out' crude spirit drinkers'" (Cook 1975: 7).

A similar account is given by the Home Office Working Party report on '*Habitual Drunken Offenders*'. A chapter of the report was devoted to the "effect on the public" (Official Publications 1971: ch. 6). There, it was acknowledged that while "the 'need' with which we are concerned in this report is that of the offender himself... the community as a whole also has much to gain" from the reduction of

social harm which would result from more effective interventions into the problem (ibid: para 6.1). The habitual drunken offender's life-style, of which his drinking was an aspect, had two sets of harmful effects, according to the working party. First there were the problems which arose from "the malfunctioning of the individual": i.e. financial cost in benefits, resources spent on socio-medical facilities, damage to property etc. Secondly, there was the harm "brought about by the actual conduct of the habitual drunken offender in public" (ibid: para. 6.2).

The working party went into the second problem in detail. It stated that, except in two areas of London, the public tended to be indifferent to the existence of the habitual drunkard, although there were some complaints from residents of coastal towns (i.e. holiday resorts) that habitual drunkards, by their appearance alone, detract from the town (ibid: para. 6.5).[6] The two areas of London referred to were the boroughs of Southwark and Tower Hamlets. Residents of these boroughs saw habitual drunkards as a "gross nuisance". The Health committee of Southwark Borough Council is cited: "These people... urinate, defecate, and vomit wherever they may be, and their clothing is filthy. Public places, subways and highways are worse for their presence" (ibid: para. 6.7). Voluntary care organisations were seen, by local residents, as exacerbating the problem by attracting habitual drunkards to the area. For local groups, compulsory detention and treatment were the only solution (ibid: paras. 6.8-.12).

These habitual drunkards would eventually be defined, among other things, as 'vagrant alcoholics' and they would be the targets of the treatment programme. There was no attempt to distinguish, in medical

terms, those habitual drunkards who were alcoholics from those who were not. This is clear form Cook's discussion of the way the target group was defined.

> . . . at no stage in the proceedings did anyone seem to wish to state who was in fact a 'crude spirit drinker' and what criteria were being used to define him. Local newspapers talked of 'methies', 'jake drinkers' and 'surgical spirit drinkers'; the London prisons reported on 'recurrent drunks'; research workers wrote about 'skid row alcoholics'. Yet all were agreed that a hostel for 'crude spirit drinkers' was needed. One document neatly illustrates the confusion: 'the task of this hostel would be strictly defined as that of helping the chronic drunkenness offender - in other words, the vagrant surgical spirit drinker' (Cook 1975: 11)

Cook goes on to state:

> After some months the term 'vagrant alcoholic' gradually came to be accepted and by the time the hostel opened in May 1966 there seemed little dispute that, whatever the social manifestations, the down-and-out drunk was in the majority of cases an alcoholic too. (Cook 1975: 12)

CONCEPTUALISATION OF THE PROBLEM

Once it had been rediscovered, the habitual drunkards problem could have been dealt with in a number of ways. In order to explain why 'treatment' was seen as the solution it is necessary to examine how the problem was conceptualised. In conceptualising the problem, the advocates of the treatment programme made certain political presumptions. I will start then with a much simplified account of the political ideology which influenced the proponents of the treatment programme.[7]

In the post World War II era full employment, rising standards of living and the establishment of the welfare state (often referred to collectively as 'the postwar settlement') led some social thinkers to revise classical social democratic theory (Clarke et al 1980: 179).

These revisionists presumed that the problems of material inequalities had been largely resolved (ibid). For them, what was now required was (a) supervision of the economy; and (b) improvement of the quality of social life, particularly by improving the capacity of 'residual' social groups to benefit from the postwar settlement (ibid). Social problems were construed as remediable through technical solutions, by improving the functioning of 'the system' (ibid).

For these revisionists, remaining social problems could be explained in terms of (i) the incompetence of certain 'residual' social groups, and (ii) "bureaucratic inefficiency and disjunctions between different welfare agencies" (ibid: 180). It was within such a paradigm that the rediscovered habitual drunkards problem was interpreted. Other newly rediscovered and closely related problems, such as homelessness (DHSS 1972) and poverty (see Clarke et al 1980), were being interpreted and conceptualised in a similar manner. These problems were seen as the result of "bureaucratic problems in the delivery of services, the lack of economic resources to make these services technically efficient, and the stubborn personal incompetence of certain groups of the population" (ibid: 180).

The proposals which emerged concerning the co-ordination and improvement of welfare services for the habitual drunkard will be returned to later in the chapter. Here I wish to examine further this perception of the habitual drunkard as an 'incompetent'. First it needs to be stressed that the habitual drunkard's incompetence was not seen as being due to mental illness. To the contrary, it was often stated explicitly that alcoholism was something other than mental

illness. While in some cases, low intelligence and mental illness were deemed to have contributed to habitual drunkenness and in others a lifetime of habitual drunkenness was seen to cause mental impairment, *a diagnosis of alcoholism did not of itself imply mental illness*. Thus it was possible to ask how much mental illness there was among alcoholics (Official Publications 1971: app. H). Also, for the Home Office working party, one of the roles of the psychiatrist in treatment programmes would be to divert those suffering from overt mental disorder.

> . . . no hostel ought to be established without . . . some procedure being devised whereby men whose principal and immediate need is treatment for mental disorder can be diverted to a more appropriate agency. (Official Publications 1971: para. 11.41)

Alcoholism was seen, not as mental illness, but as a behavioural and emotional problem. The typical habitual drunkard was shown to have had a life-long history of behavioural problems and social ineffiency.[e] In this respect he (or she) had - "a background similar to other types of social casualty, and very much the same as that which is so often found with the chronic petty recidivist and the homeless single man" (Official Publications 1971: para. 5.15). These problems could generally be traced back to the drunkard's early childhood experiences. The habitual drunkard was of 'low social class' (Official Publications 1971: para. 5.13, app. H; Hamilton 1978: ch.2). He often had a drunken - and sometimes violently drunk - father (Official Publications 1971: app. k). His early life was characterised by disorder and disturbance - the parents were often separated, or else there were frequent parental rows - and this all took place against a background of abject poverty: typically, there was - "a history of

disturbed parent-child relationships, of broken homes, and of poor home backgrounds" (Glatt 1964; see also Official Publications 1971: para. 5.14 & app. k). In short, the habitual drunkard suffered "damaging experiences during the early formative years" (Cook 1969).

The next stage of the path towards habitual drunkenness was a poor education. There was a double problem here: first, the situation of the parents generally led to the child receiving minimum schooling (Official Publications 1971: paras. 5.13, 18.2, & app. H); some "may never have had any education" (Glatt 1964: 282); secondly, the child's early experiences were likely to cause behavioural problems which interfered with his education:

> He . . . missed much schooling because of illness and frequent truancy. He could barely read or write when he left school at the age of 14.
>
> Her scholastic performance was poor, she truanted frequently and was unable to conform to school discipline. She says she was unable to write until her last year at school.
> (Official Publications 1971: app. k - '*Five Case Histories*')

This truancy was the first step in a career of juvenile delinquency: promiscuity (and possibly prostitution) in young women; house and shop-breaking, petty larceny and other misdeanours among young men (ibid). Heavy drinking usually started at this stage, i.e. 16 - 18 years (ibid). With men, delinquency was often stopped by brief careers in the navy, army or R.A.F.; often though, most of the money earned would be spent on drink (ibid).

The life of the adult habitual drunkard was marked by two closely related features: unemployment (or lack of regular employment)[9] and an inability to settle. The habitual drunkard was, in other words, a vagrant: a person without a settled home or regular work. One reason

for the habitual drunkard's inability to obtain regular employment was their lack of employment skills (ibid: para. 5.13):

> Few of them have any special skill and many have a poor work record. It is therefore not surprising that the opportunities of employment are limited; jobs in he catering trade or casual work in the markets may be the only possibilities.
> (Official Publications 1971: para. 7.38)

A second reason, however, was the habitual drunkard's inability to *hold* a steady job (ibid: para. 5.13). This inability was explained, of course, by their tendency to go on drinking bouts; but it was also seen as a consequence of the drunkard's general lack of responsibility, negative attitudes towards authority and a whole host of other negative attitudes; at least these are the assumptions which lie beneath the surface of remarks such as - "She last worked 6 weeks before her admission as a casual domestic in an institution, but left after 3 weeks following a row with her supervisor" (Official Publications 1971: app. K, case E).

The habitual drunkard's 'drifting' was explained in a similar manner. In a survey of men appearing in a magistrates' court on charges of drunkenness (which would have included many not considered as habitual drunkards) it was found that only 42 per cent had their own accomodation, 42 per cent had stayed in a reception centre and 51 per cent had slept rough (Gath 1969; see also Official Publications 1971: para. 16.5 & app. H, para. 9). Along with this there was a tendency to wander around (Cook 1975). This was seen partly as the result of circumstances; habitual drunkards had obvious difficulties in finding and paying for accomodation. But it was also attributed to an *inability* - or *unwillingness* - to settle (Official Publications

1971: para. 16.12); the habitual drunkard is a wanderlust (Cook 1975: 2).

Another common characteristic of habitual drunkard's was that they were generally either single or separated; any marriages which were entered into were generally unsettled and short-lived (Hamilton et al 1978: ch. 11). This reflected a more general problem: their failure at interpersonal relationships (ibid: ch.2). Once again drinking put an obvious strain on personal relationships, but the habitual drunkard's incompetence in this respect was also considered to have deeper causes. The habitual drunkard, it was said, deliberately tried to avoid contact with others. Hence, very few had any contact with their family (Gath 1969).

What all these problems had in common was that they contributed to, and were manifestations of, the habitual drunkard's *rootlessness*. It was the drunkard's *social isolation*, rather than his addiction to alcohol, which was his main defining feature. The habitual drunkard had little, if any, social affiliations; along with his lack of attachment to family, -

> Forty per cent had not attended a cinema, dance, church, or other social function during the proceeding five years. Less than ten per cent belonged to a club, union, or formal organisation. (Gath 1969)

With many habitual drunkards, this rootlessness was practically literal, as a large proportion (in England) were Irish and Scottish immigrants.

Closely connected with these behavioural and social problems, were a number of 'emotional' problems. The habitual drunkard was described as immature, self-indulgent, self-punitive, dependent, paranoid,

apathetic, irresponsible, as having negative attitudes towards authority and feelings of guilt, anxiety, inadequacy and rejection (Glatt 1964: 276; Hamilton et al 1978: ch.7; Official Publications 1971: para. 16.7, app. K, case E & app. N; d'Orban 1969). While not as debilitating or as irremediable as mental illness or insanity, these emotional problems were considered to be serious enough to cause social inefficiency and personal unhappiness.

These emotional problems were seen as related, in a complex way, to the habitual drunkard's social and behavioural problems. In the first place the social problems of the habitual drunkard were seen as the cause, to a considerable extent, of the habitual drunkard's emotional problems. For instance, many of the habitual drunkard's emotional problems resulted from "the lack of satisfactory adult models and the occurrence of damaging experiences during the early formative years" (Cook 1969). On the other hand, - as we have seen - the drunkard's emotional problems were often deemed to be the cause of his social problems; his negative attitudes towards authority and his irresponsibility led to behavioural problems such as truancy or an inability to hold down a steady job; and these in turn created social problems - lack of education, a paucity of employment skills and unemployment. These social problems then re-enforced the habitual drunkard's emotional problems, and so on. In short, the habitual drunkard's social, behavioural and emotional problems were seen to form a vicious circle.

This has some important implications. First, it is difficult to classify this conception of the problem as either belonging to a moral approach or as being antithetical to moral approaches. On the one

hand, it is argued that social conditions determine what the habitual drunkard is; on the other hand, the habitual drunkard's habits and attitudes are seen as the active cause of his social condition. If the habitual drunkard could be persuaded to adopt better habits and attitudes, despite the social forces which prevent him from doing so, his problems could be solved. The habitual drunkard's social problems are therefore both recognised as social problems *and* translated into problems of individual morality. Habitual drunkenness is simultaneously *'socialized'* and *'moralized'*. Social conditions are held to account, but at the same time the habitual drunkards's attitudes and conduct are scrutinised (cf. Collison 1980: 155-6). This conception of the problem provided the grounds for a blurring of the distinction between, on the one hand moral/penal intervention, and on the other, social assistance, an issue to which I will return later in the chapter.

A second implication is that the problem of alcoholism was seen as inseparable from the habitual drunkard's other problems. The habitual drunkard's alcoholism was seen as just "one facet of a constellation of problems which includes homelessness, unemployment, ill health and social inadequacy" (Moody 1979: 28). As Cook put it: "we are dealing with a complex disorder of which alcohol is a conspicuous but at times minor component" (Cook 1969). This led to two conclusions. First, and most obviously, the problem of drunkenness could not be dealt with separately from the drunkard's other problems. Contrary to what Archard suggests, there was never any question of working on one without working on the other. The habitual drunkard's social rehabilitation could not be left to social workers, while his dependency on

alcohol was dealt with by medical doctors. Unless one dealt with the habitual drunkard's social and emotional problems there could be little hope of curing his alcoholism. Secondly, and less obviously, this conception of the problem led to an inversion of the relationship between the habitual drunkard's alcoholism and his other problems. The social, behavioural and emotional problems which were uncovered in order to explain habitual drunkenness, were now seen as more important than the drunkenness itself. Correspondingly, habitual drunkenness became important, not in itself, but as a *sign* of deeper trouble. Alcoholism ceases to be the illness, and becomes the symptom:

> The pioneers have fought so hard to persuade the public that alcoholism is a disease that we may be in danger of confusing the disease with the symptom. Is not alcohol only too often the substitute-support, the substitute-security, the substitute-love which those deprived of the genuine article resort as the most easily available alternative? If so, is not our problem the common problem of mental illness - not merely to find a less degrading, less pernicious substitute support, but beyond that to attack, if we can, the root of the malady? (Silkin 1969)

'Skid Row'

This conception of the habitual drunkard might be clarified by examining how the reformers used the term 'skid row'. The habitual drunken offender was often referred to as a skid row alcoholic. The immediate reference is obvious: "Skid row was originally an American term which described a distinct geographical area with its flop-houses, pawnshops, cheap restuarants, taverns and missions" (Cook 1975: 32).[10] The term 'skid row alcoholic' referred to the drunkards who lived in these areas. In this context it was easy to see the skid row alcoholic as isolated from the rest of society, as living in a place with its own rules and norms, with its own subculture.

In Britain, there were no distinct geographical areas which would qualify for the label 'skid row'. Nevertheless, researchers started writing about 'London's skid row' (Edwards et al 1966) and the 'skid row alcoholic' (Cook 1975). This enabled them to refer to an *asocial* group of persons, living geographically within - but culturally outwith - society. Although they were not geographically isolated this group was considered to be socially isolated. They belonged to a subculture in which the fundamental habits of sociality - order, industry, providence, etc. - had no place. Hence Glatt (1964) argues that "some of these people have in fact never been socialised". The Home Office stated: "these men are not an integral part of society... they are not therefore susceptible to the normal conforming and stabilising pressures of society" (Official Publications 1971: para. 5.19). Cook (1969) described the skid row subculture as pre-social, as being characterised by "unusually regressive and primitive relations": "some of these men have in fact never been 'socialised' and need much more than the 'resocialisation' necessary for the majority of criminal alcoholics".

Skid row alcoholism was a problem therefore of maladaptation. The habitual drunkard had *internalised*, not society's norms, but those of the skid row subculture. The problem could not be solved then simply by removing the person from the skid row; in Britain the place did not exist as a geographical entity. skid row was more of a mental than a geographic space. Hence social intervention must be accompanied by psychological (or psychiatric) intervention.

> In so far as it is appropriate to talk of a skid row in England, it is possibly true to say that the phrase represents an attitude of mind, an outlook on life, a resignation to the worst society can do, a lack of belief in self and a feeling of rootlessness. It is not

> getting the man off skid row that is the problem, but getting skid row out of the man. Skid row is 'as much a state of mind as it is a place' (Ross, 1970, p. 113). There is a need, in other words, to distinguish a moral from an ecological entity. This implies considering skid row as perhaps some kind of continuous psychological territory or as an institution without walls. (Cook 1975: 32)

CRITICISMS OF 'THE PENAL REVOLVING DOOR'

In order to understand the treatment policy it is necessary to understand the criticisms which were made of the penal approach by the advocates of treatment. Two types of argument should be distinguished: first, an argument against the punishment of habitual drunkards, launched from within the terms of legal and philosophical discourse; this argument had relatively little impact upon the formulation of the treatment policy. Secondly there was an argument against using the 'penal approach' in general, and imprisonment in particular, as a solution to the habitual drunkards problem; this 'practical' critique was an essential component of the treatment programme. It needs to be stressed that neither argument was directed at punishment or imprisonment as such. Rather they argued that punishment or imprisonment were inappropriate for the habitual drunkard. That punishment and imprisonment were necessary for most other criminals was never questioned. Rather it was argued that to punish, or to imprison, the habitual drunkard was a category mistake, since the habitual drunkard, for a number of reasons, could not be considered to be 'real criminal'.

The legal/philosophical critique was more prominent in the USA than in Britain. In 1956 the American Medical Association defined 'alcoholism' as a disease. This led to a questioning of the state's

right to punish the habitual drunkard, on the grounds that it was wrong to punish ill persons for displaying a symptom of their disease (Goff 1969). This argument was put forward in actual trials, with varying degrees of success. In one case - that of J. Driver - an appeal court ruled that imprisonment of an habitual drunkard violated the constitutional ban on 'cruel and unusual punishment' (ibid). In another - Easter vs. District of Columbia - the appeal court ruled that an alcoholic does not have *mens rea* or criminal intent to become publicly intoxicated (ibid). These arguments can be located within the logic of the juridical approach to social control in which punishment is justified by reference to the notion of free will. If alcoholism is an addiction then the alcoholic's drunkenness is not a product of free will. Punishment of the alcoholic for drunkenness is therefore neither right nor purposeful.''

The campaigners for treatment in Britain seldom employed this legal/philosophical argument. Their criticism of the penal approach to the problem of habitual drunkards rested on rather different grounds. Their concern was not with the moral soundness or legal rectitude of punishment, but with the adequacy of 'the penal approach' as a means of *rehabilitation*. Their 'practical' critique was launched then, from within an entirely different framework of logics and assumptions. The practical critique presumes that the only legitimate objectives of interventon are rehabilitation and - to a lesser extent - deterrence. Interventions - such as the imprisonment or fining of habitual drunkards - are regarded almost solely from the point of view of their ability to bring about these objectives. That is to say, the penal approach is regarded as a technique, to be judged solely according to

its efficacy (cf. Garland and Young 1983: 4-5). The debate between 'the penal approach' and 'treatment' then becomes, not a philosophical/legal - nor a political - debate, but a purely technical issue.

For the proponents of treatment the problem with the penal approach was that it achieved nothing: "no one is deterred; no one is reformed" (Official Publications 1971: para. 7.8). This view was shared by those involved in prison administration. As I have suggested in appendix 1, prison administrators from the nineteenth century on had been eager to rid themselves of the habitual drunken offender. Although it was now often argued that prison could do some good for the habitual drunkard (see in particular Arnold 1969), the emerging problem of overcrowding was leading to fresh attempts to rid prisons of the habitual drunken offender. There had been recent attempts to transfer habitual drunkards to open prisons (Official Publications 1971: paras 7.14-18). Apart form a few exceptions there was a general consensus that imprisonment of the habitual drunkard was futile. The following from Lord Stonham expresses the general feeling at the time:

> The work of drying out and cleaning up these men, well knowing that they will soon be back [in prison], is a stupid waste of our badly-strained prison resources, particularly at prisons like Pentonville, where drunks account for one in six of all admissions. Neither the excellent clinic there nor the fresh air we provide at Spring Hill open prison is a substitute for the continuous support these people need if they are to be, at least partially, restored to useful citizenship. Prison is not the place."
> (Lord Stonham: cited in Official Publications 1971: ch.3)

The metaphor of 'a revolving door' was used to put across the futility of the penal approach (Pittman and Gordon 1958). The skid row alcoholic, it was said, was arrested and subsequently charged for a drunkenness offence. He then either paid a fine or served a short

prison sentence. In either event he was back on skid row within a very short time. He was returned to exactly the same social situation, with the same social, behavioural and emotional problems as he had when he entered the 'penal revolving door'. It was therefore not long before the next arrest re-started the cycle (Official Publications 1971: para. 7.8; Archard 1979: 86).

Like the nineteenth century inebriety reformers, the sponsors of the treatment programme identified two basic problems with the penal approach: (i) the prison sentence was too short for rehabilitative purposes; & (ii) imprisonment was, in any event, unsuitable as a device for rehabilitation. With regard to the first criticism, it was argued that the habitual drunkard required *long-term* psychiatric and social intervention if he was to be re-integrated into society. The short prison sentence was therefore totally inappropriate:

> The shortness of their sentences generally makes it impracticable for the prison service to undertake psychiatric treatment or even to attempt to inspire a wish to have treatment on release, or to make after-care arrangements to counteract the lack of social support they will, in the ordinary course, experience on discharge. (Official Publications 1971: 7.13)

Even if longer sentences were imposed, imprisonment would still have been considered inappropriate for the rehabilition of the habitual drunkard. One of the main reasons for this was to do with the authoritarian structure of the prison regime. Such a structure might be suitable for the *punishment* of 'real' criminals, but for the *rehabilitation* of the habitual drunkard it was wholly inappropriate; it would more than likely re-enforce the habitual drunkard's incompetence, rather than lead to his rehabilitation (d'Orban 1969). Since one of the main problems with habitual drunkards was their refusal to take on

responsibility and to make decisions, what they required was a regime which would encourage and facilitate the taking on of responsibilities. So, what was required was a democratic and permissive regime, rather than the authoritarian regime found in most prisons.[12] An authoritarian regime perpetuated the problem by making every decision for the habitual drunkard, a situation the habitual drunkard was more than willing to accept. Since the habitual drunkard's basic problem was a refusal, or an inability, to take control of his own life, a situation in which he was controlled by others was quite agreeable to him.[13]

Closely related to this is an argument made by d'Orban about habitual drunkards in Holloway prison. D'Orban argued that habitual drunkards were quite happy to go to prison, since in prison life they "found a form of social adjustment which fulfils the needs of their damaged personalities" (d'Orban 1969). It was often suggested that many vagrant alcoholics saw a prison sentence, especially during winter, as a means of securing a few weeks shelter and sustenance (Archard 1979). D'Orban argued that prison also met the emotional needs of the habitual drunkard; prison was an emotional, as well as a physical, shelter.

> . . . they have become quite dependent on the institution. They gain a sense of security and emotional support in the firmly structured and familiar community at Holloway. . . . Prison life is able to meet their physical and emotional needs better than any available alternative. (d'Orban 1969)

As such, imprisonment was deemed better than no intervention at all. The problem with prison was that by fulfiling these needs *for* the habitual drunkard, it prevented the habitual drunkard trying to fulfil

them for himself, in a normal way, through developing normal relationships and through living a normal life in the community.

Somewhat related to this is a criticism of imprisonment as offering an extreme and minimalist form of control: the habitual drunkard was either in prison and therefore subject to an authoritarian regime in which every decision was made for him, or he was at large, and hence subject to no control at all.

> . . . the dangers of relapse are greatly increased by the sudden transition from closed prison conditions to the freedom and temptation of life in the community.
> (Official Publications 1971: para. 7.11)

What was required instead was a gradual "progression towards a more liberal and normal regime" (ibid). The gap between total control and total permissiveness needed to be filled in, so that the habitual drunkard could be subject to intervention, yet still be in a situation where he could make decisions and take on responsibilities.

THE TREATMENT PROGRAMME: A. The Rehabilitation Hostel

A 'comprehensive and integrated treatment programme' was proposed as a 'constructive and positive alternative' to the penal revolving door (Cook 1969; 1971). In what follows I will discuss two aspects of this treatment programme. First I will examine the proposals concerning the regime of rehabilitation hostels for recovering habitual drunkards. These hostels were to play a central role in the proposed treatment complex. They were to provide a therapeutic alternative to the prison; being more long-term, constructive and psychologically rewarding, as well as less expensive. The 'therapy' which would be available in such hostels was quite distinct from medical treatment however; it was to be a social therapy. Secondly, I will consider the institutional base

of the proposed treatment complex. I will argue that - in this respect as in others - the treatment programme was consistent with 'social psychiatry' rather than with hospital (or asylum) based 'medical psychiatry'.

Proposals for the establishment of rehabilitation hostels for habitual drunkards formed the core of the treatment programme. At one level, the reasons for this emphasis are obvious. Since habitual drunkards were - practically by definition - homeless vagrants, providing a home was a pre-condition of treatment:

> It is worth asking at this stage why a hostel was established as opposed to some other form of 'treatment'. Other methods of treatment were in fact not debated by the working party. The crucial element of homelessness led to the position that, unless a decent roof was provided, talk of recovery or sobriety held little or no meaning for the habitual drunken offender. (Cook 1975: 14-15)

This is no doubt correct, but it is a partial explanation. The provision of settled accomodation was more than simply a pre-condition of treatment; it was one of the main objectives of treatment. Since vagrancy was a large part of the problem, leading the drunkard towards a more *settled* way of life was a large part of the solution. Although the hostel was was only a temporary place of residence (although, as we shall see in a moment, some saw hostels as a long-terms solution) it could help in settling the drunkard by providing him with a fixed dwelling place while he was put in touch with housing authorities and social services.

Even so, it is still necessary to explain why the hostel, as opposed to another means of settling the habitual drunkard, was favoured. That something deeper was at stake is clear from the fact that, at the time, it was "fashionable to talk about hostels whenever a situation

of care is under discussion, whether in the context of delinquents, ex-prisoners, epileptics, ex-psychiatric patients, unmarried mothers, or alcoholics" (Ingram-Smith 1969). The importance attached to the hostel can be explained in terms of its ideological significance. The hostel was to occupy a position *half-way* between the 'freedom and temptations of the community' and the total control of the penal institution. An alternative term for the rehabilitation hostel was, in fact, '*the halfway house*' (Rubington 1967). The hostel resident, unlike the prison inmate, would be in the community; but unlike others he would be 'sheltered' from the full pressures of independence. The hope was that from this sheltered independence the habitual drunkard would *gradually* take on more and more responsibilities and correspondingly improve his self-confidence, until he achieved a level of competence at which he could function normally without social support (Official Publications 1971: ch. 10).

Treatment then became synonymous with social rehabilitation. Helping the habitual drunkard to achieve sobriety was just one, and not necessarily the most important, objective of treatment in the rehabilitation hostel. As Cook (1969) stressed, "something more than sobriety is needed"; the aim of the hostel would be to "alter a man's self-image" and to enable them to "sustain a fully independent life in the community". More specifically, Ingram-Smith (1969) stated that one of the main aims of the hostel would be "to achieve social rehabilitation, including steady employment, reintegration into the community, and, if appropriate, reconciliation with the family." Using the words of Nikolas Rose (1986: 73), we might define the objective of the rehabilitation hostel as being "to manage the individual from a

pathology conceived of as social maladjustment to a normality construed in terms of functional efficiency". It was recognised however that this goal was impossible to achieve with many habitual drunkards; "some may require life-long support" (Cook 1969). For these, living in the rehabilitation hostel could be an end in itself (Cook 1971: 236). In so far as living in a rehabilitation hostel was the closest some would ever get to normal, domestic living, then it was desirable that they should stay in the hostel as long-term residents, rather than return to the wilderness of skid row.

Given that these were the objectives, it is not surprising to find that physicalist methods of treatment were not to play a major role. Drugs for the treatment of alcoholism were available, but these by themselves could not help to achieve the wider aim of social rehabilitation. In fact, they often failed to acheive even the limited aim for which they were designed, that of keeping the alcoholic sober: "Most residents had used Antibuse and Abstem in the past, without success, the majority of them had little confidence that these drugs could keep them sober, and had often drunk whilst taking them" (Pollak 1969). On the other hand, antidepressants and tranquillizers were considered useful, but the function of these was to facilitate therapy by combating initial restlessness; they were not intended as long-term solutions (ibid).

More important than the question of physical treatment is that of conventional psychiatric treatment. It was generally agreed that conventional methods of psychiatric treatment were of little value in the task of rehabilitating the habitual drunkard. One of the reasons why hostels were needed was because conventional inpatient treatment,

at a mental hospital, was inadequate to the task. Institutional treatment - whether in a prison or psychiatric hospital - was inappropriate because the problem had to be tackled "in the community" (Cook 1969).

> Nor is it likely that conventional hospital treatment on a larger scale would be effective. At the end of the period of in-patient treatment, the man has to return to a society in which manifestly he lacks the social skills to survive, having lost or never possessed such skills. (Gath 1969)

Nor were conventional psychiatric therapies (such as one-to-one psychotherapy or psychoanalytic group psychotherapy) considered appropriate for use in the hostel (Cook 1975: 20). While the psychiatrist was to play an important role in the hostel, he would not be directly involved in 'treatment'. The psychiatrist was to perform three functions. First, as we saw earlier, he was to assess potential residents before they were admitted to the hostel. One of the main functions of this assessment would be to rule out the existence of mental disorder (Pollak 1969; Cook 1971). Secondly, he was to act as an expert adviser to the staff of the hostel, "helping them to understand both individual behavioural problems and the group dynamics of the house" (Cook 1971: 232; Official Publications 1971: para. 11.39).[14] Thirdly, he was to participate in group meetings in the hostel (Pollak 1969; Cook 1971). The psychiatrist was not to run these group meetings though (Cook 1971: 233); it seems as if his task was to interpret the behaviour and talk of residents, rather than to 'treat' them (see Cook 1975: 20-21; cf. Rose 1986: 71).

As opposed to conventional medical or psychiatric treatment, the rehabilitation hostels were to adopt a "therapeutic community approach" (Cook 1975: 26). The therapeutic community movement was

based upon the idea that "social environment was a critical factor in the cultivation of recovery" (Unsworth 1987: 263). Hence, the Home Office working party argued that the "social structure probably holds the key to the success or failure of a hostel" and it talked about "the use of environment as an aid to therapy" (Official Publications 1971: paras. 10.27-9).

One of the key themes here was *participation and democratization*. In contrast to the hierarchical, disciplinarian regime of the prison, and the paternal, staff-directed regimes of other lodging houses, the rehabilitation hostel would be run by the residents, in co-operation with the staff. Residents would be responsible for the day-to-day running of the hostel and for deciding the overall policy of the house. The responsibilities of the residents included: "weekly parcelling and organizing of the laundry, the provision of front door keys, the paying of some of the bills, the cleaning of the house, cooking at weekends, the general management of the house... and, above all, the selection of potential residents" Cook 1975: 23).

> "We felt it was important to involve the residents more and more in policy decisions, both to relieve the strain on the staff and, above all, to make the man's stay at Rathcoole more positive and demanding." (Cook 1971: 230)[15]

This did not imply total permissiveness however. Permissive regimes, which had no rules at all and which made no demands upon the habitual drunkard, were viewed with disfavour. Hence 'permissive shelters' run by voluntary organisations, in which drinking was allowed, were accused of colluding "with the men's idea of themselves as 'hopeless drunks'" (Official Publications 1971: Ch.12). By refusing to set expectations for the habitual drunkard, one was confirming their self

image of 'I'm just an alcoholic dosser so don't ask anything of me' (Cook 1975: 19). What was required instead was "a vigourous directive approach designed to foster an attitude of self-help rather than passive dependency" (Cook 1971: 229; & 1975: 21). The rehabilitation hostel was to be run as a participatory democracy (subject to obvious limitations such as the power of the authorities to set limits, veto decisions etc.) (Cook 1971: 230).[16]

The position of the hostel, between, on the one hand, *the freedom of ordinary social living*, and on the other, the *external constraint of institutional confinement*, was to be achieved by getting the right mix between staff and resident direction. Too much staff direction created the risk of paternalism, thus "removing from the man an opportunity to examine himself and require some resposibility" (Official Publications 1971: ch. 8). Too little staff direction, on the other hand, meant that no therapy at all took place .

> It is evident that neither an under- nor an over- supportive or directive approach can be wholly satisfactory . . . and that the group approach is more likely to foster the self-confidence that a man needs if he is to function independently.
> (Official Publications 1971: para. 11.26).

This idea was reflected in the distinction which was made between the rules and '*the ethic of the house*' (ibid: para.27). Formal rules were avoided as far as possible. The only hard and fast rule in established hostels was the strict 'no-drinking' rule. This rule - along with its sanction, expulsion from the house - was decided upon by the residents themselves.[17] Otherwise formal rules were objected to because they demanded nothing of the resident, other than passive obedience: "staff direction which is expressed in terms of a list of rules does not... seem to be as *efficacious* as an approach which

demands more from the residents" (ibid: emphasis added). The hostel regimes required self-motivation and willed commitment, not just avoidance of sanctions (again, simulating normal social life and its looser controls). Moreover, the imposition of formal regulations by staff "produces in some residents resentment against rules which in a freer setting would be accepted in a more positive fashion" (ibid: ch.8). A more informal 'code of conduct' which required positive contribution, rather than passive obedience, was preferred. Only a code which was established by the residents could be effective.

Since there was quite a high turnover in the residents of hostels - partly due to the no-drinking rule - it was considered important to establish 'culture carriers'. These were residents who were settled for a considerable period; their task was to inform new residents of the code and, more generally, to ensure continuity of the culture. These culture carriers were important; first, because the hostel was seen as a site of a continuous battle between the new positive culture and the old skid row culture (see Cook 1971: 230). Every new member would take in some of the skid row culture with him; it was important that he be integrated into the new culture, rather than the whole house drift back into the skid row culture. Secondly, these culture carriers were symbols of success; they were "visible proof that recovery is possible" (Cook 1975: 102)

Most important though, was the fact that the culture carrier was not an external figure of authority, but a fellow alcoholic. The code was more likely to be taken seriously when it was clear that it was created by the residents, for themselves, and not imposed upon them.

This was particularly important when a new resident was being admitted:

> . . . the policies of the house on drinking were explained by the residents to the new man so that there was greater chance of their policies being believed, the culture was thus carried from resident to resident reducing the 'them and us' division. (Cook 1975: 24)

Or, in other words, since the code was not imposed upon the residents by 'authority', the resident was less likely to resist it in his usual anti-authoritarian manner; the reality basis of his anti-authoritarian attitudes had been removed (cf. Rose 1986: 73).

> Too often men can reject what staff say about the House but they are much less easily able to do this with fellow alcoholics. There can be no equivocation when the residents inform the potential newcomer that if he drinks he will have to leave. From the beginning the man is faced with the seriousness of his sobriety. (Cook 1971: 231)

Another key theme in the therapeutic community approach was *communalism* (Rose 1986: 74). In the rehabilitation hostel, communalism was achieved through weekly group meetings and by the establishment of an Alcoholics Anonymous (AA) group in the house (Cook 1971). The AA was a forum whereby residents could achieve greater insight into their problems and attitudes; but it also performed a more basic function of promoting a sense of solidarity. Most importantly, this solidarity was based upon the new rehabilitative culture and not upon the old skid row culture:

> "Early in 1968 the Rathcoole AA group began meeting on Monday evenings. Its effect on the House was remarkable. Talk about drinking became positive instead of humorous nostalgia about bomb-site adventures. The AA philosophy of 'a day at a time' and 'first things first' and so on, tended to make men less anxious. But above all it increased beyond measure the group spirit and wish to be involved in the House." (Cook 1971: 230)

As can be seen, one of the functions of communalism is to ensure participation from the habitual drunkard. Communalism was also

considered useful as a means of countering the skid row alcoholic's "life-long difficulties in making stable personal relationships" (Pollak 1969; cf. Official Publications 1971: paras. 8.22-40; Cook 1975: 20-22).

A third component of the therapeutic community approach was *reality confrontation* (Rose 1986: 74). In the rehabilitation hostel the first stage in reality confrontation was admitting that one was an alcoholic. Unless one realised and fully accepted what one was, then no change was possible. Group meetings were used as a means of promoting *insight* into the problem; positive and serious talk about the nature of alcoholism and the nature of recovery (is it sobriety or a change of lifestyle?) were used as means of promoting self-awareness of one's condition and hence the possibility of altering that condition (see Cook 1975: 23 & passim).

A fourth theme was that of *gainful employment*. If the habitual drunkard was to be fully restored to personhood and citizenship then it was essential that he find steady, *gainful* employment. As well as keeping the habitual drunkard occupied, gainful employment would make the person independent and no longer a burden on society. With this independence and usefulness would come self-confidence and self-respect.

> An important aspect of social rehabilitation is performance at work.... Once he is gainfully employed a man is able to pay his way, spend or save money of his own, and thus be another step towards becoming a useful member of society and being able to command degree of respect. (Official Publications 1971: para. 8.21)

Since many habitual drunkards were unable to hold ordinary employment, it was suggested that 'sheltered employment' be provided - at least initially - under the Disabled Persons (Employment) Acts 1944 and 1958

(Official Publications 1971: para. 10.23). It was also considered necessary for the hostel to have the services of a sympathetic general practitioner, who would be willing to place the alcoholic on the sick-list for a short time, during periods of acute anxiety about work (Cook 1971: 233). The need for employment also meant that hostels had to be situated in urban areas, where the jobs were.

Finally, a frequently stated concern was that the hostels be provided with material comfort. Apart from the humanitarian grounds for such a demand, it was also felt that a pleasant and comfortable environment could be an aid to therapy. It would demonstrate the advantages of domestication over sleeping rough and would be "an indication to residents that there are expectations of them" (Official Publications 1971: para. 10.29) It was considered particularly valuable if the residents were involved in the furnishing and decorating of the hostel (ibid).

Moral treatment, the inebriate reformatory and the rehabilitation hostel

From this account of the objectives, methods and underlying assumptions of the rehabilitation hostel it should be clear that what was involved was a sociological and psychological, rather than a specifically medical, conception of treatment. This conception of treatment cannot be understood in terms of the medical model. It can be better 'placed' by examining its continuities with the conception of moral treatment which was utilised by nineteenth century inebriety reformers. Despite their substantial differences, the inebriate reformatory programme and the plans for rehabilitation hostels rested

upon a similar framework of assumptions, logics and objectives. In what follows I will briefly examine some of these points of congruence, as well as some of the important differences between the inebriate reformatory programme and the modern proposals. I will not attempt an exhaustive comparison, rather I will point to some of the more general continuities in order to establish the pertinence of this line of investigation.

The fundamental objective of both the inebriate reformatory and the rehabilitation hostel was social rehabilitation. Both institutions were confronted with an asocial population, 'deficient in the fundamental habits of sociality'. Their task: to assimilate this population to society by methods of improvement; to restore the incapacitated subject to the qualities of the citizen.'[18] The same image of the adult, able-bodied citizen underlies both programmes. The ideal citizen is independent, i.e. capable of both sustaining himself and of fulfilling his obligations to society and to family without inordinate public assistance and without becoming a public nuisance. This implies a whole range of other attributes: industriousness, domestication, providence, a sense of responsibility, regularity, and sobriety. Failure to conform to this image provides the grounds for intervention; the objective of intervention is to imbue the individual with these qualities.

In both cases it was assumed that these objectives could be achieved by manipulating the individual's surroundings and by training him in the habits of sociality. It was presumed that the disorders dealt with were the product of a pathological environment and upbringing.'[19] Treatment involved countering the effects of this, by placing the

individual in better surroundings and by re-training him. Treatment was analogous to child-rearing, with the exception that not only was it necessary to socialise the individual, it was also necessary to counter the effects of a socialization to an inappropriate or 'pathological' culture'.

For the inebriety reformers confinement was a necessary condition of resocialization. It was necessary to remove the individual from his pathological surroundings and to place him in an institution in which the environment could be regulated. In the modern approach confinement was not deemed to be as necessary; in some ways it was seen as positively harmful. Beneath this difference however, lies a shared assumption. In the modern case it was also deemed necessary to remove the habitual drunkard from his pathological surroundings, i.e. from skid row. But by this time, the environment is not conceived as a geographichal entity, but as the set of social relationships. Removing the habitual drunkard from skid row now implied a social and psychological, rather than a physical process.

In these general ways, and also in many of their specific features - the emphases upon controls from within as opposed to external controls, gainful employment, the development of self-respect, and domesticity - there was a deep similarity between the inebriate reformatory programme and the rehabilitation hostel programme. Both can be understood by reference to the principles of moral treatment.

THE TREATMENT PROGRAMME: B. The Rehabilitation Complex

As I have just mentioned, confinement was no longer considered to be a condition of treatment and was seen in some respects as an obstacle

to rehabilitation. So instead of being concentrated within an institution the modern treatment programme was dispersed throughout society. The boundaries of the modern programme were therefore different from those of the inebriate reformatory programme.[20] It follows that we cannot fully understand the modern treatment programme by concentrating solely upon its operation within an institution. We have to examine a wider set of proposals concerning the establishment of "a co-ordinated treatment service" for habitual drunkards. A detailed account of these proposals would be well beyond the scope of this chapter. Instead I will try to identify their underlying logic and some important effects of this more dispersed form of intervention.

Along with rehabilitation hostels the treatment system was to consist of other "facilities" for habitual drunkards. These included detoxification units where the habitual drunken offender could be taken when arrested, instead of being put through the penal revolving door (Official Publications 1971: ch.15; Cook 1975: ch.6; Hamilton et al 1978). These detoxification would preferably be established in psychiatric hospitals. It is interesting to note, however, that one experimental detoxification unit was established in a Regional Poisoning Treatment Centre which was staffed by ordinary medical personnel. This soon proved unworkable mainly, it seems, because of the attitudes of the medical personnel, who refused to see habitual drunkards as genuine medical cases (Hamilton et al 1978).[21] The detoxification unit would undertake functions currently performed by the police and prison service - 'drying out' the habitual drunkard under medical supervision, cleaning him up, and so on - without

resorting to criminal procedures. It would also attempt to educate the habitual drunkard about alcoholism, help him find accomodation for when he leaves, and try to motivate him to enter the treatment system (ibid). The basic difference between this and the penal approach was that while the latter had no official interest in the habitual drunkard once he had paid a fine or his prison sentence had been served, the detoxification unit would attempt to keep the habitual drunkard within the treatment system. While the penal approach returned the habitual drunkard to skid row, the detoxification centre would attempt to put him on the path to rehabilitation.

It was also envisaged that detoxification centres would 'catch' the habitual drunkard who had lost his place in a rehabilitation hostel for breaking the rules against drinking (Hamilton et al 1978). Such units could therefore help ensure that once the alcoholic had entered the treatment complex he would only leave it through the door to normal society. In contrast to the penal revolving door, the path through the treatment complex would start at skid row and end up at normal society. Although it was a slippery path, those who slipped back would be caught and prevented from ending up exactly where they started.

It was also proposed that facilities such as 'shop-fronts' be established (Cook 1975: ch. 4). These would be established in areas where skid row alcoholics tended to congregate. Staffed by social workers and recovered alcoholics, their function would be to provide a place where the habitual drunkard could drop-in for a couple of hours warmth and companionship. This would help establish initial contacts with the skid row alcoholic, without frightening him off with pressure

to change his life-style. Once the habitual drunkard had become used to these surroundings, efforts could be made to motivate him to undergo treatment. Those who appeared to be good treatment prospects could then be referred to the appropriate agency.

Along with the establishment of new facilities the treatment programme proposed that existing agencies and facilities, which came into contact with habitual drunkards, be integrated into the treatment network. These existing agencies and facilities included (a) official agencies: such as the probation and after-care service, the prison service, the courts, the police, psychiatric clinics, hospitals, and the Supplementary Benefits Commission: and (b) facilities run by voluntary, charitable organisations, such as crypts, shelters, and lodging houses (Official Publications 1971: chs 7-9 & 12-13). If these facilities were to play a more positive, rehabilitative role they would often have to be changed in certain aspects of their operations. This reshaping would be achieved through the giving of professional, expert advice. Such advice was considered particularly pertinent where voluntary, charitable agencies were concerned.

If all these agencies were to operate effectively it was essential that they be co-ordinated (Official Publications 1971: ch.14: Cook 1975: passim). Co-ordination would ensure that the habitual drunkard's social and psychological needs (as intepreted by social workers and psychiatrists) were met as fully and as efficiently as possible. It would prevent duplication of services, and therefore inefficiency. Co-ordination would also mean that each agency understood the work of the others. A particular agency would therefore know where appropriate help for a particular habitual drunkard was available and would be

less likely to make inappropriate referrals (such as referring an alcoholic in need of detoxification to a rehabilitation hostel). Co-ordination would also facilitate the compiling of biographical details of habitual drunkards, information gathered by one agency could be added to a central file, and therefore be available to all others. This knowledge of the habitual drunkard would also help to achieve the most important objective of co-ordination: preventing the habitual drunkard from slipping through the treatment net. In a co-ordinated network of treatment facilities the habitual drunkard would not leave one agency or facility without being referred to another. Sometimes this would represent an advance along the rehabilitative path, e.g. a move from a detoxification unit, to a rehabilitation hostel. In others it would prevent the habitual drunkard from slipping too far back along the path: the shop-front, for instance, would enable a relapser to stay in contact.

The treatment network would also include agencies such as alcohol information centres which would disseminate information and advice about alcoholism. One of the functions of such centres would be to educate and advise those who had drinking problems, but who were not (yet) alcoholics. Treatment would therefore perform a prophylactic function. It would prevent the potential alcoholic from drifting into skid row by ensuring intervention at an earlier stage than would otherwise be the case.

In general then, this co-ordinated range of treatment facilities was intended to bridge the gap between skid row and the normal community; facilitating the movement from the former to the latter. It would also

mean that those without the competence to live a normal life-style were not condemned to skid row. Those who were not capable of independent social functioning could live in a rehabilitation hostel, on a long-term basis. Although receiving continuous support they would be able to take on some degree of responsibility and independence.

The treatment complex would also fill in the gap which existed between punitive intervention and non-intervention. These relatively simple choices offered by the juridical approach were to be supplemented with a wide range of non-punitive and non-institutional interventions into social problems. This could have two sets of implications. In the first place, some persons who - under a juridical approach to social control - would be considered beyond the scope of control (i.e. those who did not break the law) could now be brought within the 'social control net'. It is important to stress however, that these persons would be subject to a less punitive and more 'assistantial' form of social control than that which is considered appropriate for offenders. The other implication is that some of those who were convicted of offences and were usually dealt with through the conventional punitive techniques of prison and fine could be dealt with through less punitive, more assistantial forms of social control.

This conception of treatment could also lead to a filling in of the gap between between penal intervention and assistance. The relatively simple choice of penal intervention or assistance would be supplemented by a whole range of partly punitive, partly assistantial options. This, in turn, would make questions about the 'worth' of offenders less central. It would no longer be always necessary to make an either/or choice between whether the person was willfully dissolute

and therefore deserving of punishment or a victim of circumstances and therefore in need of assistance (although the possibility of placing a person in either of these categories would still exist). Such choices could be increasingly avoided as a range of 'facilities' were established between the penal and the assistantial.

CHAPTER 5

MORAL INSANITY, MORAL IMBECILITY AND PENAL POLICY IN THE NINETEENTH CENTURY

INTRODUCTION

The term 'moral insanity' - which was coined by J. C. Prichard in the first half of the nineteenth century (Prichard 1837) - appears frequently in penal and social discourses of the nineteenth century (cf. Donnelly 1983). In the second half of the nineteenth century a closely related but distinct term, 'moral imbecility', began to appear in penal and social discourses. Both of these terms began to fall into disuse from the beginning of the twentieth century, as they were replaced by a new term, 'psychopathy'. In this study I will examine how these terms have been used in the discourses of penal policy,' but before proceeding with this task I will look very briefly at conventional accounts of the formation and develpment of these concepts. I will then look, once again very briefly, at some of the main objections which have been lodged against these concepts by sociological sceptics. The purpose of this is to show that both conventional and sceptical accounts presume that these terms have been used in a specifically medical-scientific sense. In the rest of the study I will try to show that, to the contrary, medically-founded knowledges have contributed relatively little to the formation and development of these categories, rather they have been constructed, for the most part, upon the basis of social-psychological theories and knowledges. I will also try to show that the formation and development of these concepts cannot be understood by looking in abstract at

developments in medical or psychiatric ideas. Rather the meaning of these concepts can be best understood by placing their formation and development in the context of specific social and institutional problems for which psychiatry and criminal justice have endeavoured to provide solutions.

Conventional accounts of the development of these categories

In conventional accounts of this development it is suggested that the use of each of these concepts in penal discourses represents various stages in a transformation from a 'moralistic' to a scientific perception of affectionless, anti-social offenders (Butler 1975; cf. Prins 1980: Henderson 1939). These accounts point out that before Prichard coined the concept of moral insanity only those who were severely deranged *intellectually* - i.e. those who had little or no capacity for reason - were regarded as insane (Prins 1980: 140). Those who were not intellectually disordered, but who nevertheless persistently acted in an anti-social and self-defeating manner and showed no feelings or concern for the fate of others or themselves, were simply regarded as grossly *depraved* characters. For these accounts, this failure to '*recognize*' such characters as mentally disordered is explained by "the rudimentary state of psychological knowledge" (Prins 1980: 140).

In the first half of the nineteenth century some 'medical psychologists' began to argue that insanity was not confined to intellectual derangement, and that there were '*affective*' or '*emotional*' disorders which which were also types of insanity (Henderson 1939; Prins 1980: ch.5). In Britain, Prichard coined the

term 'moral insanity' to refer to this form of 'character disorder' and the category included those emotionless, anti-social characters who were once seen as simply depraved. This concept had important consequences for penal policy since it implied that it was wrong to deal with those morally insane persons who broke the law - and given the nature of the condition such transgressions were frequent - as criminal justice cases. Rather they should be dealt with in the same way as insane persons were dealt with, i.e. they should be confined and treated in an asylum (or similar institution) until their condition had been cured.

D. K. Henderson, an influential writer on psychopathy, suggests that while the concept of 'moral insanity' represented a considerable advance in psychological theory, it was not a scientific concept since it was based upon the purely 'hypothetical' notion that there existed a 'moral sense', independent of the reasoning faculty. Henderson argues that the existence of the 'moral sense' was never established scientifically, rather it had been simply 'posited' by late eighteenth century 'empiricist' philosophers.[2] The category 'moral insanity' was therefore constructed at a time when psychology was still at "the philosophy of mind stage" (Henderson 1939: Prins 1980: ch.5). In the late nineteenth century, so the story goes, there was a transformation in the nature of psychological knowledge. There was a shift away from psychology based upon 'philosophical speculation' to psychology based upon positive, scientific knowledge.[3] This transformation led psychologists and pscyhiatrists to reject the notion of an independent moral sense (Henderson 1939). With this rejection it became clear that the term 'moral insanity' was a misnomer (ibid: 11). Hence the term

psychopathy was adopted by psychiatrists such as Kraepelin, who was among the first to undertake scientific 'research' into the condition. Research into psychopathic personalities has continued ever since. The condition has, however, proved to be extremely difficult to explain and even more difficult to modify by treatment.

The controversy over 'moral insanity', 'moral imbecility', and 'psychopathy'

> With the possible exception of 'maladjustment' no other diagnosis has had such difficulty in establishing its status as a genuine clinical label; and there are signs that both are proving too vague and unsatisfactory for professional use. Other disorders have symptoms which only occasionally bring the sufferer into conflict with the codes of behaviour of his society, but the symptoms of psychopathy almost invariably do so.
> (Walker and McCabe 1973: 205)

This statement from Walker and McCabe, which identifies 'psychopathy' as one of the most controversial psychiatric categories, could also be applied to the categories of 'moral insanity' and 'moral imbecility' which preceded psychopathy. The formation and development of these categories has been accompanied by controversy and dispute. Among those who have tried to understand and treat these 'disorders' there have been the usual disputes about the nature of the condition, its aetiology, and the best methods of treatment (Prins 1980: ch.5). Such disputes are quite common; they occur with regard to most other psychiatric categories. There are also, however, more fundamental disputes within the discipline of psychiatry about whether conditions such as psychopathy do in fact exist. Some psychiatrists have asked whether psychopathy is "a concept or a chimera" (ibid). It has been suggested that if psychopathy is difficult to understand and almost

impossible to treat, perhaps it is because psychopaths are, after all, simply wicked, recalcitrant delinquents (ibid).

This questioning has been taken further by those who have looked at the concept of psychopathy from outside of the discipline of psychiatry. It has been pointed out that so-called 'psychopaths' are diagnosed as such, not because of the presence of any objectively verifiable form of mental disorder, but because they are extremely impulsive, hedonistic and irresponsible in their conduct and attitudes. Such deviancy, it is argued, cannot necessarily be equated with mental disorder since many persons are deviant without being victims of mental disorder (Critchley 1951: 39-40; Wootton 1959: part II). To equate deviancy with mental disorder is therefore circular and hence logically defective. The psychopath is;

> *par excellence*, and without shame or qualification, the model of the circular process by which mental abnormality is inferred from anti-social behaviour while anti-social behaviour is explained by mental abnormality. (A. Lewis, cited in Wootton 1959: 250)

For Wootton, Lewis, and many other critics of the concept of psychopathy, the development and use of these concepts (i.e. moral insanity, moral imbecility, psychopathy) is the result of confusion (Wootton 1959; Lewis 1974). Psychiatrists have simply failed to realise the ambiguities and contradictions inherent in the concept of psychopathy: "The volume of literature on the subject of psychopathy is rivalled only by the depth of the confusion in which this literature is steeped" (Wootton 1959: 250).

Over the past few decades, however, sociological critics have put forward a somewhat different interpretation. They have argued that such concepts have been used, *despite* their circularity and

incoherence, because they perform the useful functions of legitimizing the social control of a group of troublesome persons and promoting the interests of certain groups within the psychiatric profession. This argument has been made most forcefuly by Shulamit Ramon (1986) who argues that despite the criticisms which have been lodged against the category of psychopathy, and despite the therapeutic failures, psychiatrists still use the term - and the State still supports psychiatric interventions into psychopathy - because of the functions which the concept performs. Ramon argues, for example, that during the Second World War, psychiatrists used psychiatric categories such as psychopathy to explain high levels of aggression and cruelty. Such explanations were useful, Ramon argues, because by explaining such behaviour in individualistic, psychological terms, psychiatry shifted attention away from the social factors which cause aggressive and cruel behaviour and therefore enabled a shifting of guilt for such behaviour "as far as possible from the arena of collective responsibility" (ibid: 220). Ramon also argues that the category of psychopathy was supported by the therapeutic community movement because it gave it a foothold in society (ibid: 239). Most importantly, however, Ramon argues that the category of psychopathy was adopted by the Home Office because it places a 'smokescreen' of medical expertise around a questionable practice of social control (ibid: 240). So, despite all its logical contradictions, the category of psychopathy;

> . . . has a function nonetheless. It enables the state to accomplish the social management of a troublesome group of individuals, and it enables psychiatry to maintain and sustain its mandate over those whose conduct is socially undesirable yet who do not fall within the ambit of our system of criminal justice. (Ramon: 1986: 240)

Conventional accounts assume that psychopathy is a real condition, which is knowable through psychiatric concepts and treatable through psychiatric techniques (although the precise concepts which will reveal the true nature of psychopathy are yet to be developed and effective treatments have still to be discovered). The critics of the concept, on the other hand, have argued that there is no such condition as psychopathy and that 'psychopathy' is therefore nothing more than a medical label attached to those who display no symptoms of mental disorder but simply act in an anti-social manner without showing any remorse. What both accounts share in common is the view that the formation and development of the concept of psychopathy is the product of a transformation from a moral to a medical conception of anti-social conduct. While conventional accounts celebrate this transformation as a sign of progress in our way of thinking about and responding to those with 'character disorders', critics argue against such medicalization on the grounds that it distorts the moral and political issues raised by anti-social behaviour and its control. The critique of the concept of psychopathy is based upon the presumption that the term 'psychopathy' is in fact used in a specifically medical sense (what is challenged is the assumption that 'psychopathy' is a genuine medical or psychiatric condition). In this study I will try to show that the reality is in fact more complex and somewhat different. I will try to show that the categories of moral insanity, moral imbecility and psychapathy have been used in a variety of ways and that in penal discourse they have been used primarily as social-psychological and administrative categories.

THE CATEGORY OF 'MORAL INSANITY'

In this chapter I will start by presenting a brief exposition of the concept of moral insanity. I will then look at how the concept was utilised in penal discourses. This task is a complex one since the concept of moral insanity was utilised, not in a single debate, but in a number of distinct, but intersecting, debates over legal, penal, social and psychiatric policy. The picture is further complicated by the fact that the concept of moral insanity was *not* utilised in a consistent manner; 'moral insanity' was neither a univocal category, nor a uniform condition. In order to examine the use of the concept in the discourses of penal policy it is necessary to appreciate this complexity. The impact of 'moral insanity' cannot be traced along a single axis, rather its variety of uses and its corresponding variety of implications - which were often contradictory - need to be traced. In order to do this it is necessary to reject the image of a single battle between law and psychiatry, an image which permeates both conventional and sceptical accounts of the formation and development of the concept. It is necessary instead to trace a number of distinct conflicts, and a number of distinct uses of the concept, while also showing how they intersect. The result will be a more complex map of the various ways in which the category 'moral insanity' was employed in penal discourses than that suggested by the notion of a gradual medicalisation of deviance. The result should also be a more adequate and more accurate account of how the concept of moral insanity has influenced and shaped penal policy.

Although the concept of 'moral insanity' was anticipated by a number of early nineteenth century 'medical psychologists', such as Arnold, Pinel and Esquirol, the term was first formally proposed by J. C. Prichard in his work *A Treatise on Insanity* (1837).[4] Prichard criticised the then dominant conception of madness which he considered to be too intellectualistic, in that it restricted the concept of insanity to defects of reason: "It is generally supposed that the intellect or the reasoning faculty is principally disordered in persons labouring under mental derangement . . . this is by far too limited an account of madness". There were other types of insanity, he argued, such as moral insanity, in which the persons capacity to reason was unaffected, his intellectual powers remained intact, but the *moral sense* was impaired:

> the intellectual faculties appear to have sustained but little injury, while the feelings and affections, the moral and active principles of the mind, are strangely perverted and depraved; the power of self-government is lost or greatly impaired; and the individual is found to be incapable, not of talking and reasoning upon any subject proposed to him . . . but of conducting himself with decency and propriety in the business of life . . ." (Prichard 1837)

This concept was expounded in Prichard's psychiatric writings, where it was often given a strict, diagnostic meaning. Persons who suddenly, and for no explicable reason, underwent a substantial change of character were diagnosed as morally insane. Moral insanity was diagnosed where a person started conducting himself in a manner which departed radically from his normal pattern of behaviour. The crucial point is that although moral insanity was diagnosed upon the basis of departures from norms, the norms departed from were established by the person himself in his own past conduct. For example, a moderate drinker who suddenly, for no apparent reason, started getting drunk

every night, might be diagnosed as morally insane, whereas a person who had a long history of drunkenness would not - in the strict, diagnostic application of the concept - be diagnosed as such. As Donnelly puts it, a diagnosis of moral insanity:

> . . . was strictly applicable only to individual case histories which evidenced sudden or inexplicable changes in a person's 'moral sensibility', demeanour, and disposition. The norms from which it represented a gross deviation were themselves 'individual', given in the person's past 'normal' self, which the madness had perverted. Thus the case-histories of the morally insane commonly described their perversion of affections by contrast to, and as a sudden and immoderate departure from, their previous normal and sane conduct and feelings. (Donnelly 1983: 138)[5]

Moral insanity as a 'social' category

However, as Donnelly also points out, the concept of moral insanity was often interpreted more loosely, and employed in accounts - not just of individual patients - but of the cultural traits, ways of living, and mental characteristics of *social groups*, especially the labouring classes and the poor (ibid). It was used, in particular, to account for criminal behaviour and other anti-social and immoral conduct, such as habitual drunkenness (ibid: 137-8; see Symonds 1869). In such accounts the concept was used to describe general deviations from social norms, rather than an individual's departure from his own moral sense. By the same token, the practical relevance of the concept was not restricted to its impact upon the treatment of those individual patients who were diagnosed as morally insane; the concept also had an impact upon social policy in general. More specifically, it was deemed pertinent to those social practices which were concerned with *moral improvement*, i.e. with improving the morals and habits of the population, and especially those of the poorer classes. So while

the concept had an immediate impact upon the fate of a relatively small number of persons who were diagnosed as morally insane - either to justify their confinement in an asylum or to help them to avoid the legal punishment for an offence - it also had a more general impact upon those social groups who were the target of policies designed to promote moral improvement.

This broader interpretation and usage should not be understood as a distortion of Prichard's concept, or as a deviation from the concept's true meaning. The relationship between the restricted, technical use of the concept and its more general usage was much more complex than the notion of distortion suggests. The two uses were already present in Prichard's writings. Although Prichard proposed the concept of 'moral insanity' in his psychiatric writings, the category also occupied an important position in his more general - and much more voluminous - writings on 'the history of mankind'.[6] As we shall now see, in those writings Prichard constructed a concept of moral insanity which owed more to 'anthropology' and 'social theory' than to psychogical medicine.

One of Prichard's concerns in his more general works was to defend religious doctrines concerning the unity of mankind. This led him to challenge the idea that "there exists in mankind several distinct species" (cited in Leigh 1961: 195). Prichard contended, to the contrary, that all human beings were endowed with a common nature. In order to support this contention it was necessary for him to explain the causes of variations - both physical and psychological - between different people, and especially between different races. The answer

was, in a sense, contained within the question: if the variations could not be explained in terms of *nature*, then they had to be due to *culture*. More specifically, physical variations were attributed to the effect of the environment upon physical structure. Prichard subscribed to an environmentalist theory of heredity in which the environment - i.e. "climate and modes of life, domestication, etc." - directly *influenced* physical characteristics, which were then transmitted to offspring, via the ovum (see Leigh 1961).

Prichard explained variations in mental structure between the different races in similar terms. All men, he contended, were endowed with a common intellectual and moral *nature* (ibid). Variations in mental characteristics between different races were due to the degree to which the intellectual and moral nature had been *cultivated*. The most barbarous races were those in whom the intellectual and moral nature had been least cultivated, the civilised races were those in whom it had been most cultivated. But why were some races were more cultivated than others? For Prichard the differences were, once again, due to the effect of environment. A wild environment would produce savage sentiments; a more moderate, domesticated environment would produce a more civilised, moral sensibility. These sentiments were then transmitted through heredity.

Prichard did, however, implicitly posit an important difference between physical and mental structure: the latter was apparently more fluid, and hence more modifiable, than the former. This difference is one of degree: according to Prichard's thesis, physical structure was modifiable, but modification would take place slowly over a number of generations. Prichard often implied, however, that the mental

structure of a person could be modified within that person's lifetime. Prichard's claim was that, if subjected to a moral environment, the savage was biologically capable of becoming an 'Englishman' (ibid), i.e. capable of adopting the ideas and sentiments of 'the civilised races'. The moral and intellectual nature of the savage could be cultivated; the savage could be morally improved.[7]

Intersection of the 'individual' and 'social' meanings of 'moral insanity'

Prichard often assimilated the insane with primitive and savage people in respect of their basic psychology (Donnelly 1983: 167-8). The explanation of variations in mental structure between *races*, was thereby converted into a explanation of mental variations between *individuals*. The insane stood in the same relation to their more rational (or more moral) fellows, as savage races stood in relation to civilized races. The insane differed from others in terms of the *backwardness* of their moral and intellectual nature. The insane person's moral and intellectual senses had been weakened - sometimes through physical injury or heredity, but often through living in an immoral environment - leaving them in a state of mind somewhat akin to that of the savage. And crucially, as Prichard made clear in his psychiatric writings, the *moral sense* could be damaged while the *intellectual sense* seemed to be unimpaired. One could therefore be morally insane, without exhibiting any defects of reason. Here, Prichard anticipated later psychiatrists such as Maudsley and Tredgold, who argued that the moral sense is the highest of the senses, the latest to have been acquired and hence the easiest lost,

or the most commonly absent.[8] A generation later, Maudsley (1879) would argue that the moral sense was "the last acquisition in the progress of humanization, and its decay is the first sign of the commencement of degeneracy".

Analysis of the concept

From what has been said it should be clear that Prichard subscribed to an environmentalist theory of evolution. As Nye (1984: ch.4) has argued, such environmentalist or Lamarckian versions of 'evolution' would prove to be far more popular than strict Darwinism, among nineteenth century psychiatrists and scientists.[9] A number of points need to made about such environmentalist theories, and about Prichard's theory in particular. First, although such theories can be described as environmentalist, they were not opposed to hereditarianist theories (cf. Rose 1985: ch.3; Hirst & Wooolley 1982: 43-58). It is therefore wrong to try to classify such theories as *either* environmentalist or hereditarian. The opposition between environmentalism and hereditarianism - an opposition which has structured so much of the debate over the category of psychopathy (see Prins 1980) - is an inadequate one for analysing these theories since it fails to grasp their complexity. In Prichard's account, mental characteristics were both acquired (through interaction between the person and the environment) and inherited; acquired characteristics were passed on through heredity.

Also, such theories cannot be easily classified as being either voluntarist or determinist. They appear, on the one hand, to be determinist in that they argue that conduct is the product of 'moral

sense', which is in turn the product both of heredity and the environment. There are at least two - closely related - reasons, on the other hand, for not classifying such theories as determinist. First, we should consider the way in which the environment was conceived. As Prichard used the term, the environment included not only relatively 'fixed' items such as climate, but also items which were presumed to be within the individual's control, such as 'modes of life' and 'domestication'. Individual cases of moral insanity might be brought on, for instance, by a person's adopting an immoral or undomesticated mode of life. Intemperance, promiscuity, idleness, and other forms of immoderate behaviour, along with disorderliness, uncleanliness, and lack of domestication in general, were all habits which could create the conditions in which moral insanity might occur.

Secondly, the relation between the environment and the person was conceived as one of *'influence'*, rather than one of straightforward determination. In environmentalist theories of the time, the environment was seen as exerting an influence upon the physiological, nervous and psychological traits of the person (cf. Aron 1965: 40-41). A particular environment would be *favourable* to the appearance of certain traits, but would not directly cause them (ibid). In other words a certain environment would make moral insanity likely, but not inevitable. Similarly while heredity could *predispose* one towards moral insanity, moral insanity could not be directly transmitted through heredity.

These two ideas - the concept of environment as being partially the individual's creation and the idea that the environment influenced but did not absolutely determine mental characteristics - opened up a

space between free will and determinism, and therefore between responsibility and non-responsibility, and between ethics and science. They made it possible to show how a person's conduct was not simply the product of free choice, that it was influenced by the environment and by heredity; but at the same time, they left open the possibility the the person could, by an exercise of will, overcome the effects of environmental and heredity influence. The person could improve his environment, to some degree, by the adoption of moral - i.e. moderate and domesticated - habits. Also, the person could, through exercising his will, overcome the influence of an immoral environment. The person's will was a weapon against environmental influence. Where that will was weakened - through immoral and undomesticated habits, then the person would become a slave to environmental influence. Eventually he would more than likely become morally insane. Correspondingly, it was not a contradiction to ascribe moral insanity to a person (or to a social group) and at the same time to criticise that person's, or that group's, conduct as unethical, as was in fact done (Donnelly 1983; Smith 1981: 114).[10] Through the theory of moral insanity, the person was attributed with a residuum of responsibility for his condition and for his conduct. While the theory made conduct an object for scientific knowledge and intervention, it did not facilitate any removal of conduct from the domain of choice and therefore of ethics.

IMPLICATIONS FOR CRIMINAL LAW

In comparison with the ideas of some later psychiatrists, Prichard's view of the implications of 'moral insanity' for penal practice was rather restricted. For Prichard the concept was to be used to extend

the scope of the insanity defence, so that the morally insane - as well as those with defective reason - could be excused punishment (see Prichard 1837: 271-3). An immediate impact of the concept, then, was to open a long controversy within law, and between law and psychiatry, as to how insanity should be defined for legal purposes. This was related to a more general issue as to how far the law should amend its practices in response to knowledges - psychological knowledge in particular, but also that of other human sciences - which appeared to contradict legal theories of responsibility.

It is important to remember what was at stake in this conflict. At the time - and indeed up until the abolition of capital punishment in 1957 - a successful plea of insanity would save an offender's life. Instead of being hung, the offender would be confined indefinitely as a criminal lunatic. This is important since the legal recognition of moral insanity, as a condition which diminishes moral responsibility, and therefore should excuse from full legal responsibility, would quite clearly have a humanizing influence upon penal practice. The concept of moral insanity therefore acquired an amount of goodwill, at least in reformist circles. But this goodwill could also help to promote other uses of the concept, in contexts where its implications were not quite so obviously humanitarian.

Traditionally, the law had restricted the insanity defence to those who were obviously and grossly mad, using crude tests such as the wild beast test and the right-wrong test.[11] In the late eighteenth and early nineteenth centuries the law refined its practice somewhat, giving these tests more precise definitions (Donnelly 1983: 71-3).

However it still restricted the insanity defence to those those who were quite clearly suffering from defects of reason (ibid). Prichard, and other psychiatrists were now arguing for a further refinement in light of their 'discovery' of new 'partial insanities', of which moral insanity was one of the most important. However, within a decade of the publication of Prichard's treatise on insanity, the intellectualist conception of insanity had been reaffirmed as the one which should guide criminal law. The key event here was the establishment of the M'Naghten principles.

In 1843 Daniel M'Naghten was put on trial after he "shot and killed Sir Robert Peel's private secretary while believing himself to be persecuted by the police, supposedly on instructions from the Tories" (Smith 1981: 14). M'Naghten's defence counsel - in what would undoubtably be seen by some as an attempt to 'depoliticise' political actions by having their perpetrators designated insane - argued for M'Naghten's acquittal on grounds of 'partial insanity'. The trial then became the site for a battle between those who wanted to restrict the legal definition of insanity to disorders of the understanding and those who wanted a much wider range of partial insanities (including moral insanity) to be recognised as grounds for acquittal. In the event M'Naghten was acquitted. In an unprecedented move, however, the issue of the correct ambit of the insanity defence was referred to the judges of the House of Lords. They proposed the famous 'M'Naghten Rules' which reaffirmed the traditional, intellectualist 'right-wrong' test.

> . . . to establish a defence on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing;

> or, if he did know it, that he did not know he was doing what was wrong. . ." (cited in Smith 1981: 15)

The M'Naghten principles have been derided by commentators - from within both the legal and the psychiatric professions - ever since (see Clyne 1973). The attraction of such conceptions of insanity to the law has been explained, however, by Wootton (1959: especially pp.228-31). The M'Naghten Rules are attractive to law because of their narrowness and simplicity, and because they avoid circularity (ibid). Where insanity is equated with intellectual deficiency it can be inferred from criteria *external* to the actual offence. This makes it easier - particularly for those who are not medical experts - to distinguish beteen the sane and the insane offender. Defects of reason, it is presumed, can generally be relied upon to reveal themselves, or at least they can be detected with the use of objective tests. The M'Naghten principles therefore avoid the circular argument that the offender 'must have been mad to do such a thing' (ibid). They therefore make it possible to draw a line "between those whose offences are explained by illness, and those who cannot legitimately plead ill-health as mitigation of, or excuse for, their conduct" (ibid). The problem with extending the scope of the insanity defence - and of moving beyond strict intellectualist conceptions of insanity - is that it then becomes difficult (or impossible) to find a test of insanity which is *independent* of anti-social conduct. If anti-social conduct becomes, in itself, evidence of insanity, then crime and insanity become indistinguishable.

In short the advantage of the M'Naghten principles is that they *'exteriorize'* the relation of crime to madness (cf. Castel 1975).

Crime may be an incidental feature of madness but it is not defined as its essence; other independent evidence must exist for the condition to be diagnosed. Conversely, the concept of moral insanity is unacceptable to the juridical forms of thought because it appears to conflate crime and insanity; it implies that certain types of delinquency are, in themselves, evidence of madness. If we return to Prichard's argument, however, it seems quite clear that it also 'exteriorizes' the relation of crime to madness. In his 1847 essay '*On the Different Forms of Insanity in Relation to Jurisprudence*', Prichard acknowledged the fact that;

> . . . it is often very difficult to pronounce, with certainty as to the presence or absence of moral insanity, or to determine whether the appearances which are supposed to indicate its existence do not proceed from natural peculiarity or eccentricity of character." (J. C. Prichard, cited in Skultans 1975)

For Prichard, however, this was a *practical*, rather than a *conceptual*, problem. He therefore argued for a greater role for medical experts in criminal trials, since only the physician with wide experience of dealing with the insane could recognise moral insanity (see Skultans 1975: 6-7). Nor was Prichard alone in thinking this. During the 1850s and 1860s the *Journal of Mental Science* carried a number of articles by psychiatrists on how 'homicidal mania, without disorder of intellect' - a condition close to moral insanity - could be detected by "those who know how to look for it" (Robertson 1860), and on how to distinguish the genuinely insane from those who feign it too escape punishment (Davey 1859).

It seems clear from this that Prichard was using the concept of moral insanity here in the restricted sense mentioned earlier, i.e. as a deviation from *individual* norms. Presumably the medical expert would

examine the offender in order to determine whether there had been some sudden or inexplicable change in the his moral sensibilities. In the article by Robertson, mentioned above, it was argued that "In every case of homicidal insanity without intellectual disorder, some previous aberration from the standard of mental health will be found" (Robertson 1860). Although moral insanity was thereby diagnosed on the basis of anti-social behaviour, the anti-social behaviour was not, in itself, treated as evidence of insanity. Anti-social behaviour would only lead to a diagnosis of moral insanity if it constituted a departure from the pattern of behaviour which the individual had established for himself. So although Prichard argued for a conception of insanity wider than that relied upon by the law, his argument still left crime and insanity external to each other.

A SHIFT IN FOCUS: From the Insanity Defence to Penal Policy

Defence lawyers continued to seek acquittals on grounds of moral insanity right up until the 1940s.[12] In recent decades they have tried to have murder charges against 'psychopaths' reduced to verdicts of manslaughter on grounds of diminished responsibility (see Walker and McCabe 1973: 215 - 218). By the second half of the nineteenth century, however, the concept of moral insanity was already being utilised by those with a much more ambitious project in mind: a radical alteration of the social control system.[13] The sponsors of this new project showed little concern for the traditional question of how insanity was to be defined by the law. Instead they entered a much larger conflict, a conflict between classical penal thought and psychiatry over the social regulation of 'the criminal class'. Correspondingly, there was

a shift in the way the concept of moral insanity was used. The concept was applied now, not so much to individual cases, but rather to a whole category of persons: habitual criminals. The broader, social interpretation of the concept now became dominant.

This shift can be seen in the pages of the *Journal of Mental Science*. In the 1850s and early 1860s the journal carried a number of articles specifically concerned with the scope of insanity defence. From the mid-1860s on, these articles get fewer, while a new concern emerged and began to dominate: a concern with the psychology of the criminal class. For a brief period these concerns were intertwined (e.g. Symonds 1869; Haynes 1864/5). Within a few years though, articles on the new subject - the psychology of criminals - made little or no reference to issue of the insanity defence (e.g. Thomson 1870 & 1871). Within the space of a few years the insanity defence had become a peripheral issue for 'medico-legal science'; the central concern was now with the new problem of the criminal class.[14]

Thomas Laycock might be considered a pivotal figure in this shift of psychiatric attention. In a lecture bluntly titled '*The Antagonism of Law and Medicine in Insanity, and its Consequences*', Laycock raised the familiar issue of the difference between legal and medical conceptions of insanity: "Medicine says a man may be insane and irresponsible, and yet know right and wrong; law says a knowledge of both right and wrong is the test of both soundness of mind and responsibility to the law" (Laycock 1862). So long as law refused to listen to medicine, many insane offenders would be, unjustly, put to death:

> Thus law, as recently expounded in the English courts and the English legislature, is entirely antagonistic to medicine on all

> those questions of mental science which involve the freedom and well-being of the imbecile and the insane, and which often determine whether they die an ignimonious death or not. (Laycock 1862)

In the same article, however, Laycock hints that medical intervention can achieve something else, besides wresting the morally insane from the hands of the executioner: "Medicine says restrain and cure the insane and imbecile offender against the law; law says hang, imprison, whip, hunger him, and treats medical art with contempt" (ibid). Previously psychiatry had merely asked the law to excuse certain offenders from the normal punishment for their offence. Now it was making a rather different demand: restrain and cure the insane and imbecile offender, rather than simply punish him. It is important to notice though, that already Laycock appears to be using the term insane and imbecile offender much more broadly than before.

Some years later Laycock's concern with the insanity defence had faded into the background. In an article titled '*Medico-mental Science and the Prevention of Crime*', he confidentally asserted: "That medico-mental science is often at variance with the doctrines of and decisions of the courts of law is a fact too well known and too generally admitted to need formal proof" (Laycock 1868). His attention had by then shifted to a rather different - and in terms of numbers involved, infinitely larger - problem:

> . . . there is a large number of criminals termed in France the 'classes dangereuses' and in English phrase 'known to the police' and another still more numerous body, not exactly of this class, but incorrigible vagabonds, drunkards, mendicants. All these, numbering tens of thousands, are really so constituted corporeally that they possess no self-control beyond that of an ordinary brute animal. . . They are, for the most part, immoral imbeciles, so that however frequently they may have been subjected to prison or other discipline, the moment they are set free, they resume their vicious and criminal course. (Laycock (1868: 342)

MORAL IMBECILES, THE BORN CRIMINAL, AND THE CONFLICT BETWEEEN CLASSICAL PENAL THEORY AND CRIMINAL ANTHROPOLOGY

The 'criminal class' was not an obvious category. To the contrary, such a class was unintelligible to the prevalent penal rationality. For classical penal theory criminals had nothing in common except for the fact that they had *chosen* to commit crimes. It was presumed that criminals were like non-criminals in their essential characteristics, i.e. free will and rationality; they differed from others "only in the contingent and non-essential fact of their law-breaking" (Garland 1985: 14) If there were other differences between the criminal and the non-criminal, such differences had no status within classical penal theory and hence there could be no special allowances made for them in penal practice.

For the criminal class to become conceivable the prevalent penal rationality had to be confronted. What was later to become an established fact - the existence of the criminal class - still had to be asserted explicitly at this stage. One of the main purposes of an article by Thomson, in 1870, was to assert: "1. That there is a *criminal class* distinct from other civilised and criminal men; (and) 2. That this criminal class is marked by peculiar physical and mental characteristics" (Thomson 1870: emphasis in original). The category of moral insanity, and the closely related category of moral imbecility, played a crucial role in establishing this argument. It was largely in terms of the category of moral imbecility that the criminal class was conceived and represented. The essential distinguishing feature of the criminal class was said to be their moral imbecility. The argument that "violent and habitual criminals are, as a class, moral imbeciles"

(Thomson 1871) was to form the basis of a sustained attack upon classical penal rationality throughout the remainder of the nineteenth century.

Henry Maudsley was one of the chief exponents of this idea. Like Prichard, Maudsley often used the concept of moral insanity as an individual diagnosis; he claimed that moral insanity was diagnosable on the basis of deviation from individual norms: "In extreme cases it is observed that the modest man becomes presumptious and exacting, the chaste man lewd and obscene, the honest man a thief, and the truthful man an unblushing liar" (Maudsley 1870). Maudsley was, in fact, well aware of the problems involved in generalising the link between crime and madness. He acknowledged that moral insanity was "a form of mental alienation which has so much the look of vice or crime that many persons regard it as an unfounded medical invention" (Maudsley 1874).[15] He argued, however, that although the 'symptoms' of moral insanity and vice were the same (i.e. anti-social conduct), moral insanity was nevertheless an authentic condition which could be (and should be) evidenced by factors other than simple delinquency:

> . . . the evidence of disease will be found in the entire history of the case. What we shall often observe is this - that after some great moral shock, or some severe physical disturbance, in a person who has a distinct hereditary predisposition to insanity, there has been a marked change in character. . ." (Maudsley 1874).

However, Maudsley also argued for the existence of 'moral imbecility', a condition closely related to moral insanity (see Burt 1925: 34-6). It is necessary to examine this concept in a some detail since, although closely related, there is a crucial difference between moral insanity and moral imbecility.

In the domain of intellectual defects, the insane had already been distinguished from mental defectives: while the insane had *lost* their ability to reason, mental defectives had *never developed* it. Loss of mind was distinguished from lack of mind (ibid; cf. Jones 1972: ch.8). In the first half of the nineteenth century there was a move towards extending the category of mental defectives to include *imbeciles*, imbecility being defined as a mental defect which was not quite so severe as the long-recognised condition of idiocy (Jones: ibid).

In a similar manner Maudsley drew a distinction between the morally insane - those whose moral sense had been damaged by severe 'moral shock' or 'physical disturbance' - and moral defectives: the moral defective was a person who had never developed a moral sense in the first place (ibid). This condition was said to correspond to imbecility, hence the term 'moral imbeciles'. It was this category which was applied to the criminal class: ". . . if there be a class of persons who are without the moral sense, who are the true moral imbeciles, it is the class of habitual criminals. . . " (Maudsley 1870).

Moral imbecility did not, however, relate to moral insanity in exactly the same way as 'intellectual imbecility' related to 'intellectual insanity'. The crucial difference between 'intellectual insanity' and 'intellectual imbecility' was that while insanity was generally attributed to disease in later years (although heredity could predispose a person to insanity), and was considered potentially curable, imbecility was considered to be an hereditary, or inborn, and permanent condition (Burt 1925: 34-6).[16] The 'symptoms' of insanity and imbecility were more or less the same (i.e. gross deviation from a

given standard of reasoning ability); the conditions differed in terms of their cause and curability. Likewise, moral imbecility was distinguished from moral insanity on the grounds that it (moral imbecility) was an inborn and hereditary condition and that it was incurable. However the 'symptoms' of moral imbecility were also different from those of moral insanity. Whereas moral insanity was diagnosed on the basis of deviation from norms of conduct established by the individual, moral imbecility was inferred from the transgression of social norms. The moral imbecile had, by definition, always acted in an anti-social manner. Unlike the concept of moral insanity then, the concept of moral imbecility *did* appear to lead to a generalisation of the link between mental abnormality and crime. The concept of moral imbecility implied that those who persistently acted in an anti-social manner 'from birth or from an early age' were suffering from a form of mental defect. Through the concept of moral imbecility, Maudsley 'interiorized' the relation between delinquency and mental disorder.

This difference between the category of moral insanity and moral imbecility was never acknowledged by Maudsley, nor by others who promoted the concept of moral imbecility. In fact, during the second half of the ninteenth century the two terms were often used interchangeably (see Watson 1988). Also, the same method was used to illustrate cases of moral imbecility as was used to demonstrate cases of moral insanity. This method was the biographical case-history.[17] The relevance of the biography to diagnoses (and illustrations) of moral insanity was obvious: it could be used to determine whether there had been a sudden change in character, a sudden departure from

the norms of conduct established by the individual for himself.[18] The biography could not be used to establish moral imbecility in the same way, since in moral imbecility the person had always acted in an anti-social manner. The biography of a moral imbecile could only establish that a person had a life-long history of delinquency. What happened in fact was that the language used to describe the instances of delinquency read 'moral imbecility' *into* the conduct, while professing to infer moral imbecility from the conduct. Nevertheless, writers such as Haynes (1864/5) switched from biographies of moral insanity to biographies of moral imbecility as if they were one and the same thing.

Biographical case studies of moral imbeciles did not establish what was claimed for them, i.e. the existence of moral imbecility as a medical condition distinct from ordinary delinquency. These studies *did* however, draw *a* distinction between the moral imbecile and the 'ordinary delinquent', but this distinction was at the level of description of the conduct, not at the level of its cause. The main use of the biographical case study was, in fact, to present a detailed portrayal of the *type of character* the moral imbecile was. This aspect of the writings on moral imbecility has generally been overlooked by critics of the concept. I would argue, however, that the representations of the moral imbecile contained in biographical case studies has had an important and lasting impact upon penal policy (and more generally upon cultural conceptions of delinquency); an impact which is at least equal to that of arguments about biological determinism, which are generally the focus of attention. It is

necessary then to consider these biographical illustrations in a little detail.

The biographies of moral imbeciles all told a similar story, only the specific details differed.[19] First, there was the family background: in nearly all cases of moral imbecility there was some family history of insanity (which was generally considered to be proof of the hereditary nature of moral imbecility). In the early years the child was often either spoiled or treated very harshly. School years generally saw the start of serious delinquency, but also of other problem behaviour such as throwing tantrums. By adolescence, moral imbecility was clearly recognisable. The adolescent moral imbecile indulged, in various degrees, in masturbation, promiscuity, lying, stealing, fraud, and other forms of delinquency. Much of this delinquency was without purpose; objects stolen, for instance, were often of little use to the moral imbecile. Moral imbeciles were not only bad though, they also tended to be sad. They were unable to relate normally to others and appeared to be unhappy with themselves: they were quarrelsome, they tended to be loners, they were easily excitable and prone to sudden and impulsive outbursts of violence; they were sometimes suicidal; and they often lived in a fantasy world. Needless to say, the moral imbeciles conduct often brought him into conflict with authority. The moral imbecile was always in trouble, first with his parents, then at school, and later on with employers and the police.

All these features add up to an extremely troublesome person. There were one set of factors, however, which distinguished the moral imbecile from other troublesome persons. Moral imbeciles displayed a

striking detachment from their deeds. They seldom showed any regret or remorse for what they had done and seemed not to appreciate the affect of their conduct had upon others. Characteristically, they often described their deeds, even ghastly killings, in matter-of-fact, neutral terms.[20] Moral imbeciles displayed a "deplorable want of *feeling* as to what is right and wrong" (Haynes 1864/5: case 15, emphasis added - see app. B). This could not be explained, however, by intellectual defect. Moral imbeciles were not insane or imbecilic in the usual sense. To the contrary they were often of more than average intellect. They were perfectly capable of understanding the difference between right and wrong, in the sense that they were *cognisant* of the difference (ibid). They seemed, however, to be unable to *appreciate* or *be affected by* the difference between right and wrong. They were aware of the distinction, but the distinction itself made no impression upon them. They were totally destitute, not of intellectual sense, but of *moral sense* (ibid).

It can be seen that although the emergence of the concept of moral imbecility occurred as part of a change in the way of certain types of delinquent were perceived, this change was not towards a medical perception of delinquency. Rather, there was a more complex change in the way the delinquent was perceived. In the first place a distinction was drawn between those in whom a delinquent act was an isolated ocurrence and those in whom the act was simply one more offence in a life-long history of delinquency. The latter were referred to as 'moral imbeciles'. As we saw in the chapters on inebriety such distinctions owed little, if anything, to medically-founded knowledge, rather they were made by looking at the 'moral history' of the

delinquent. Secondly these 'moral imbeciles' were represented as having different '*characters*' from the one-time offender and from non-offenders. As we shall see, although this difference in character was generally explained by reference to the physical make-up of the person, it was also often presumed that environmental factors played an important role in shaping the character of moral imbeciles. In any case, what is important is not simply how the basis of the difference was understood, but the fact that 'moral imbeciles' were seen as different. What was novel about the concept of moral imbecility was that it referred to a class of persons who, for whatever reason, were impervious to society's norms. These characters therefore represented a threat to the social order.

CRIMINAL ANTHROPOLOGY

The term 'moral imbecility' was often used to refer to all 'habitual criminals' (i.e. all recidivists). Recidivism was often deemed to be, in itself, sufficient proof of moral imbecility. But many psychiatrists - and especially those with a direct influence upon penal policy and practice - soon rejected such broad usage and began to use the term in the more restricted and specific sense, rejecting the argument that all habitual criminals were moral imbeciles (cf. Garland: 1988). Others, however, continued to generalise the link between moral imbecility and recidivism. This tendency was, in fact, taken further in the study of *criminal anthropology*.

Lombroso, conventionally designated the founding father of criminal anthropology, explained criminality in terms of *atavism*, 'a hereditary

regression to the behaviour and appearance of a primitive human ancestral type' (see Nye 1984: 99). Lombroso argued that about forty per cent of offenders were 'born criminals', persons who had inherited a large number of primitive characteristics. Their behaviour was therefore that of the savage. While savage behaviour might have been appropiate in savage times, it was now intolerable and hence branded criminal (see Gould 1978). Lombroso's argument was in many ways similar to that of Prichard, a generation earlier. While Prichard had drawn comparisons between the behaviour of savages and that of madmen, Lombroso compared the behaviour of lower animals to that of the criminal. Lombroso argued that 'the usual behaviour of lower animals is criminal by our standards' (ibid: 224). He then examined the anatomy of criminals to show that criminals were throwbacks to our evolutionary past (ibid). The criminal, he claimed, had many features, not only of lower primates, but also of lower mammals and even of flatfishes (ibid: 225). These physical stigmata were accompanied by mental and social signs of atavism. Noting similarities between criminal slang and the speech of savage tribes, Lombroso concluded: "They speak differently because they feel differently; they speak like savages, because they are true savages in the midst of our brilliant European civilisation" (cited in Gould 1978: 225). Once again it can be seen that Lombroso's views were more complex than the argument for which he is often credited with - i.e. that criminals are biologically inferior (cf. West 1988). In order to assess Lombroso's contribution to criminology it would be necessary to pay more attention to the use he makes of the concept of 'atavism'.

Havelock Ellis (1910 - first published in 1890) was chiefly responsible for disseminating criminal anthropology in Britain.[21] Ellis argued that the criminal, as well as being an evolutionary throwback, was also a moral imbecile. As was the case with Prichard, Ellis linked psychiatric with anthropological designations of delinquency. Ellis expressly welcomed Prichard's attack upon "the conception of insanity then ruling among English lawyers, by whom it was regarded as a purely intellectual matter". However, he also criticised Prichard's *use* of the concept of moral insanity as being too restrictive, arguing that the cases which Prichard used to demonstrate moral insanity were "clearly insane in far more than 'moral' respects" (Ellis 1910: 33). According to Ellis all those who constituted the criminal class - i.e. persistent delinquents as opposed to the 'political criminal' or the 'criminal by passion' (ibid: ch.1) - could be seen as moral imbeciles (ibid: 33 & 285-6). For Ellis the 'born criminal' and the 'moral imbecile' were one and the same thing (ibid: 292). As against Prichard's concept of moral insanity, Ellis in fact preferred that of the German 'alienist' Grohmann, who expressly realised that "there are no clear lines of demarcation between the insane and the criminal" (ibid: 288 ff).

Where both Maudsley and the criminal anthropologists diverged from Prichard was in their insistence that moral imbecility was an inborn, permanent condition. As we saw earlier, while Prichard argued that mental and moral characteristics were passed on through heredity, he also presumed that these characteristics - unlike physical characteristics - could be substantially altered during the term of a person's life. Maudsley and the criminal anthropologists argued to the

contrary; once a defective moral sense had been inherited, it could not be altered, or at least not for the better. One's moral nature was biologically determined, just as physical characteristics were; it was a part of one's constitution (and of course, for the criminal anthropologists, there was a strong relationship between physical and moral defects). As Ellis put it:

> . . . the average criminal, whatever injustice he may have suffered at the hand of society, is at the same time often a more or less congenitally abnormal person, endowed with an ill-adjusted organism which fails to respond to the same social stimuli as the organisms by which it is surrounded . . . (Ellis 1910: xiv)

And, to run ahead a little, we might note that this argument was often used to support claims that the moral imbecile was irreformable:

> A true reformation would be a re-forming of the individual nature; and how can that which has been forming through generations be reformed within the term of a single life? Can the Ethiopian change his skin, or the leopard his spots? (Maudsley 1870)

Implications for penal policy

As was the case with moral insanity, the concept of moral imbecility was utilised in attacks upon juridical theories of criminal responsibility. However, whereas in previous attacks the focus was upon the occasional, serious offender who was diagnosed as morally insane, now it was upon a large proportion of offenders - recidivists - who were categorised as moral imbeciles. And the purpose of the attack was not to suspend the legal punishment for an offence in a few cases, rather it was to remove juridical restrictions upon the exercise of social control, at least where the object of control was a member of the criminal class. What was at stake was not an individual's life, but the partial replacement of one style of social control with another.

As we have seen, juridical forms of thought placed definite limits upon the exercise of social control: the liberty of a person could not be infringed unless that person committed a punishable offence, and *punishment* had to be proportionate to the offence committed. These restrictions were tied, however, to the juridical conception of the person as a self-governing, rational individual (see ch.1). Hence it was often accepted that where this presumption was rebutted, as in the case of the lunatics or mental defectives, these restrictions could be set aside to some degree.[22] It was generally agreed, by all but the most extreme liberals, that lunatics - *provided they were properly certified as such* - could be confined without being found guilty of a definite legal offence. Such confinement was generally justified as necessary to protect both the lunatic and society against the lunatic's dangerous propensities and lack of competence (ibid).[23]

The argument that a large proportion of offenders were moral imbeciles can be seen as an attempt to extend this logic: if those suffering from mental defects of an intellectual nature could be confined for reasons of social defence, then those suffering from mental defects of a moral nature should also be subject to such confinement. Moral imbeciles, it was argued, should be subject to the same form of social regulation as were lunatics and other mental defectives. It was argued in fact, that the need to control moral imbeciles was even greater, since their high level of intelligence, combined with a lack of moral sense, made them an even greater threat to society than the ordinary mental defective (Ellis 1910: ix). The argument then, was that the moral imbecile should be subject to the same sort of social regulation as the lunatic, and not given the

protections to which the normal person was entitled. To deal with the moral imbecile in the same way as one dealt with ordinary offenders was to make a category mistake. The moral imbecile, or the born criminal, was not an ordinary offender; although he was not insane or mentally defective, the moral imbecile was not normal either (ibid: xxiii).

What can be noted about this argument is that it does not pose a direct challenge to the logic of juridical punishment. Juridical punishment already excluded the insane from its jurisdiction; it was now being argued that moral imbeciles should be considered on a par with the insane, rather than with normal persons. So, despite rhetorical attacks upon "the antiquated traditions concerning 'responsibility' which rule in our courts of law", and upon attempts to deal with the criminal through "the antiquated blunderbuss of punishment" (ibid: xxiv-xxv), it is clear that the objective was not to abolish legal restrictions upon social regulation altogether, rather it was to abolish restrictions upon the control of a certain class of persons, the 'criminal class'. By arguing that members of the criminal class were not mentally normal, special controls could be justified for them, while the social regulation of the ordinary person was still guided by the principles of juridical punishment. Criminal anthropology re-enforced the appeal of this argument; as Radzinowicz and Hood put it:

> The definition of a criminal class as a separate and foreign social species implied that decent citizens had nothing to fear from a jurisprudence tailored for, and applicable only to, this element. (Radzinowicz and Hood 1986: 231)

The concept of moral imbecility therefore lent scientific legitimacy to the developing concerns of social policy. The criminal class, a social category,[24] was represented as a race apart; its members were represented as psychologically and physically, as well as morally, inferior to the normal citizen. Special forms of control - designed for them, but not for the ordinary citizen - could therefore be represented as both necessary and justifiable. The category of moral imbecility was therefore put to an ideological use. It is important to realise though that this did not involve a misuse of the category. Psychiatrists did not overstep their position by applying the category of moral imbecility to the criminal class. This is precisely because 'moral imbecility' was not a neutral, scientific concept, rather the category of 'moral imbecility' was constructed, as we have seen, by direct reference to social norms. The category was properly applicable to criminals since it was partly the product of a new analysis of criminality. And I might add that this new analysis of the nature and causes of criminality employed social knowledges and moral theories, as well as medical and psychiatric ideas.

The concept of moral imbecility was used, not simply to argue for more social control over the criminal class, but to argue for a specific form of control. Ellis, for instance, relied on the concept in order to support three sets of penal policy proposals: (i) eugenic proposals for the sterilization of habitual criminals; (ii) the introduction of indeterminate sentences for habitual criminals; & (iii) proposals for prison reform.

(i) *sterilization of habitual criminals*: In keeping with his view that moral imbecility was an hereditary condition, Ellis supported eugenic

proposals for the sterilization of habitual criminals and other methods - e.g. permanent segregation - of preventing moral imbeciles breeding offspring whose moral sense would be even more defective than their own, and thereby "lowering the level of civilisation in the community" (Ellis 1910: xiii; 1939: 10).[25]

(ii) *the indeterminate sentence*: Whereas others had used the concept of moral insanity to attack the *right* to punish, Ellis employed it in order to point to the inadequacies of punishment "as a practical tool for dealing with criminals in a civilised state" (ibid). Punishment, Ellis pointed out, was based on the presumption that the criminal was, like other persons, a responsible being. According to Ellis, however, it had now been established that the criminal was not in fact a responsible person, that he was a moral imbecile. This being the case it was useless to approach the criminal "with the antiquated blunderbuss of punishment" (ibid). The criminal could not be controlled in the same way as the ordinary person, for whom the threat of punishment was generally sufficient to prevent delinquency. Rather the control of the criminal should be put on the same basis as the control of other dangerous lunatics. In particular, it was necessary to reject the classical principle of proportionality between crime and punishment when dealing with the moral imbecile. Criminals could not be dealt with by "simply meting out to them 'punishments' in the form of a term of imprisonment roughly equivalent to what social opinion and the judge considered to be the size of the offence, a method which is merely a transformation of the old *lex talionis*" (ibid: preface to 4th edn). Instead of punishment being determined by the crime the "*treatment* of offenders must be so far as possible individualized and

directed not so much towards the crime as towards the criminal" (ibid, emphasis added). The criminal, in other words, must be confined for as long as he remained a threat to society: ". . . the indeterminate sentence. . . is really as cardinal a principle in the treatment of prison inmates as of hospital inmates, while from the point of view of social protection it is even more necessary" (ibid).

(iii) prison reform:- Ellis proposed the establishment of a *'moral hospital'*, an institution which would be the equivalent in the domain of moral disorder, to the lunatic asylum in the world of intellectual disorder: "We used to chain our lunatics. Our lunatic asylums during the past century have become mental hospitals. Our prisons must now really become what it was long ago said they ought to be, moral hospitals" (ibid: preface to 3rd edn.)[26] In arguing this, Ellis was not necessarily arguing that prisons should be replaced by hospitals. We might just as easily interpret Ellis as engaging in the familiar business of imagining the ideal prison; an institution which instead of being a place of moral contagion would be capable of reforming the character and morals of criminals. Hence Ellis supported the Borstal institution as a good example of a prison run on modern and intelligent lines (ibid: preface to 4th edn.). For Ellis, the ideal prison would incorporate certain features of the hospital (most notably the principle that the person should not be released until he was 'better') but it would also incorporate elements from other institutions such as the technical school: "It is now becoming recognised that the prison must have in it elements borrowed from the hospital, the lunatic asylum, and the technical school, while yet remaining distinct and apart from all these" (ibid).

What is notable here is that eugenic proposals - which are clearly based upon a conception of moral imbecility as an hereditary condition - are combined with proposals concerned with the reform of the criminal. The presumption that the criminal might be reformed is obvious in the proposals for prison reform. The proposal for indeterminate sentences also reveal such a presumption. Indeterminate sentences would only make sense if the there was some hope of the criminal's reformation; if the criminal were truly irreformable, permanent exclusion rather than an indeterminate sentence would be the logical policy. The idea of moral imbecility as a natural, hereditary condition did not lead automatically then to the contention that the moral imbecile was irreformable. As we saw earlier, it was often argued that whereas mental defectives could not be cured, they might be improved. From reading Ellis's policy proposals we might say that he made a similar presumption, that moral imbeciles cannot be cured, but some moral improvement was possible. Wheras one's moral nature was virtually as unalterable as one's physical constitution, this did not automatically mean that the moral imbecile was beyond moral improvement, despite rhetorical statements to that effect. For Ellis, the moral imbecile should be prevented from breeding, but should also be subjected to reformatory techniques.

CONCLUSIONS

The concepts of moral insanity and moral imbecility cannot be said then to have had a single impact upon penal policy in this period. The concepts were not used in a consistent manner, but took on different meanings in different contexts, with a corresponding range of

implications; implications which were often contradictory. Notions such as the 'medicalisation of deviance' - which suggest a singular path from an explicitly moral conception of deviance, towards a scientific medical conception - are inadequate for understanding the develoment of these concepts and their impact upon penal policy. The notion of medicalisation is also clearly inaccurate, most obvioulsly because a wide range of knowledges - not specifically medical, nor even psychiatric - contributed to the meaning and the development of the concept.

More importantly though, even the specific psychiatric theories of moral insanity and moral imbecility cannot be simply classified as medical, or at least not without considerable qualification of the term 'medical'. If medically qualified professionals became important figures in the domain of penal theory in the nineteenth century it was not through applying conventional medical concepts to previously moral problems, but by developing a new type of knowledge; a knowledge which can be placed between morals and medicine, and between ethics and science. More specifically, while the notion of medicalization tends to emphasise the emergence of a biological-determinist view of delinquency over voluntarist and environmentalist theories, I have tried to show here that the categories of moral insanity and moral imbecility cannot be classified as biological-determinist; the concepts were also clearly based upon voluntarist and environmentalist assumptions.

The point, however, is not simply that the concepts of moral insanity and moral imbecility cannot be classified as biological-determinist; rather I have tried to show the inadequacy of basing

analysis of the concepts solely upon the conventional questions of voluntarism vs. determinism, environmentalism vs. organicism, and so on. An exclusive focus upon these questions prevents us from understanding the broader impact which the categories of moral insanity and moral imbecility have had upon penal debate and penal policy, and upon conceptions of delinquency. To mention just two important points: First, the concepts helped to disseminate the idea of the criminal as an undercivilised character. This was to become a constant theme (although cast in very different terms) in twentieth century accounts of psychopathic personality. Secondly, in different ways the concepts of moral insanity and moral imbecility contributed to the establishment of the biographical case study as an important aspect of criminological knowledge. Such studies were to play an important role in twentieth century penal theory, providing an alternative to the psychological technique of mental testing as a way of assessing character.

CHAPTER 6

THE INTRODUCTION OF 'PSYCHOPATHY' INTO PENAL DISCOURSE

INTRODUCTION

In this chapter I will describe how the category of psychopathy was introduced into penological discourse. I will argue that the origins of penological discourse on psychopathy cannot be properly understood by concentrating solely upon developments in medical and psychiatric knowledge and by asking how these were brought to bear upon penal policy. Instead, it is necessary to examine developments in penal and social policy which led to the formation of the penological category of psychopathy. The concept of psychopathy which was employed by penologists was not a medical concept which penologists had reluctantly recognised. Rather penologists played a major role in forming and developing a category of psychopathy which owed little to medically-founded knowledge. This argument disturbs both conventional and sceptical presumptions about the origin and development of the concept of the psychopathic offender.

Conventionally 'psychopathy' is regarded as a specifically medical concept (see ch.5). This is based upon a further presumption, that 'psychopathic disorder' is a pathological condition which was *recognised* by medical experts as a result of clinical observation and scientific reasoning. If we then ask how this medical concept came to occupy such an important place in penal discourses, something like the following explanation emerges: One of the *symptoms* of psychopathy is a propensity towards delinquency; psychopathy is typically defined as a condition which "*results*" in severely anti-social conduct (See

Official Publications 1957: para. 166). In other words, psychopaths, *because of their condition*, often transgress social norms and hence become offenders. Whereas the symptoms of other psychiatric disorders only sometimes bring the sufferer into conflict with the criminal law and other social norms, the symptoms of psychopathy almost invariably do (Walker & McCabe 1973: ch.9). So, those who are suffering from psychopathic disorder, and hence are the subject of medical concern, often end up in the penal system. Medical and penal interests therefore *coincide* over the issue of 'the psychopathic offender'. Medicine *recognised* psychopaths as patients to be dealt with according to the principles of treatment, but criminal justice mistakenly regarded them as ordinary offenders to be dealt with according to the principles of punishment. It was therefore necessary for medical experts, and other enlightened penal reformers, to *persuade* penal policy makers that the medical perception of psychopathy was the correct one and that law and penal practice should be reformed so that psychopaths could be dealt with as medical patients rather than as ordinary offenders. Hence, it was necessary for medical experts to discuss psychopathy in a penal context. The introduction of the category of psychopathy into penological discourse is presumed, then, to be contingent upon the fact that psychopaths happen to break the law often. If it weren't for the psychopaths propensity to break the law, medicine could have got on with the task of investigating psychopathy and treating psychopaths without ever having got involved in the debate about what to do with the psychopathic offender.

Here I will challenge the basic presumption that psychopathy is a specifically medical concept. I will argue that the concept of

psychopathy which was employed in penal debates was formed and developed within a penal, rather than a specifically medical context. If this argument is accepted, then it is no longer necessary to ask how a medical concept found its way into penal discourse. We can regard the concept of psychopathy as indigenous to penal discourse.

Underlying the idea that psychopathy is a specifically medical concept is the presumption that psychopathic disorder is a mental condition, which has always existed, but which only became known to us when medicine *recognised* its existence. A major problem with this presumption is that nobody has ever actually pin-pointed the moment when psychopathy was first recognised. The term psychopathy was first used in the late nineteenth century, but the actual recognition of psychopathic disorder - as a distinct mental disorder or group of disorders - is generally regarded as having occurred much earlier.

> It is probable that philosophers and physicians had *recognised* the group of so-called 'psychopathic disorders' as early as the seventeenth century. Certainly 150 years ago French and German psychiatrists had done so.
> (Official Publications 1975: para. 5.4, emphasis added)

This quotation is from the Report of the Committee on Mentally Abnormal Offenders (also known as the Butler Committee), which contains a major review of the problem of psychopathic offenders. The Butler Committee do not provide evidence for the claim that psychopathy had been recognised since the seventeenth century, but refer us to another leading work on the history of psychopathy, that of Walker and McCabe (1973: ch.9). But when we turn to Walker and McCabe's text we find that they simply cite, as a precursor of the modern concept of psychopathy, Burton's aphorism - put forward in his *Anatomy of Melancholy* (1621) - that the difference between ordinary

persons and madmen was one of degree rather than an essential one. To interpret this as evidence that Burton recognised the existence of psychopathy is speculative, to say the least.

The Butler Committee are on sounder ground when they designate the French and German psychiatrists Pinel and Gröhmann as the early recognisers of psychopathy. At least these psychiatrists' definitions of "moral diseases of the mind" such as '*manie sans délire*', 'congenital brutality' and 'moral dullness' bear a striking resemblance to many modern definitions of psychopathy. However there is no evidence that these psychiatrists recognised or discovered 'moral diseases'. All we know is that they *asserted* the existence of such diseases.[1] Like Prichard (see ch.6), Pinel and Gröhmann did not present any independent proof of the existence of moral disease; they simply inferred moral disease from a person's pattern of conduct.

If writers on psychopathy are hazy about the precise moment when psychopathy was first recognised it is because they are equally hazy about what psychopathy actually is. One would expect accounts of the recognition of psychopathic disorder to define psychopathy; that is to say, one would expect them to tell us what it was that psychiatrists recognised. However, psychopathy is seldom precisely defined.[2] Nor is this failure to define psychopathy a simple oversight; writers on psychopathy have often admitted that they are unable to define psychopathy.[3] The closest which many writers come to a precise definition is to suggest that psychopathy is a mental disorder which results in extremely anti-social conduct. This, however, can mean a number of things. It might mean, for instance, that psychopathy is a physically-based mental abnormality which causes anti-social conduct.

This is clearly the perception of psychopathy held by those who initiate research projects with the objective of finding biological or cerebral abnormalities which can explain psychopathic conduct (e.g. Fabisch 1966). However if this is what psychopathy is, then the pathology involved has never been recognised, nor has its existence ever been proved. Pinel and Gröhmann never undertook any research into the physical causes of moral disease. Even more recent medical research into psychopathy has failed - as those who have undertaken it admit - in its attempt to prove the existence of biological or cerebral abnormalities which can explain (or are even consistently associated with) 'psychopathic' conduct (ibid).

Often though, it is *implied* that psychopathy is something less tangible, or more abstract, than a physically-based condition. Psychopathy is often perceived, not as a mental condition with a physical basis, but as a purely mental disorder - a disorder of the mind with no physical basis. Such a conception of psychopathy is clearly based upon a perception of the mind as an abstract entity with no corporeal existence and no specific relationship to the body. If this is the case then psychopathy must be regarded more as an abstract concept, rather than as a name attached to a tangible entity. But if psychopathy is an abstract concept, and not a physical condition, then it is meaningless to talk about the recognition of psychopathy as if it were a definite event. It would be more correct to talk about the formation of the concept.

Writers of conventional accounts of psychopathy do, of course, often realise that they are writing about the development of a concept, and not simply about a series of scientific observations. However, they

tend to write about this conceptual development as if it were dependent upon a process of scientific discovery. The origin and development of the concept of psychopathy is still regarded - even by those who eschew any reference to a physical basis of psychopathy - as the product of a gradual increase in our *knowledge and understanding* of the mind and of the *types* of mental state - such as psychopathic states - which exist. This 'advance' in our understanding of the mind is particularly associated with the adoption of positivist method in the study of mind: it is implied that, whereas in previous eras reflections on the mind were merely speculative, modern psychological theories are based upon positive knowledge.[4] In such accounts we might interpret the term 'the recognition of psychopathy' as referring to a gradual process whereby scientific reasoning and research helps us to understand the *truth* about the mind and helps us to realise that there is a mental state which can be described as psychopathy.

This version of 'the discovery of psychopathy' still faces the problem of locating a moment when psychopathy was correctly described, or stating when speculation gave way to positive knowledge. For instance, we might expect such accounts to tell us about the discovery of some psychological attribute which could fully explain psychopathic conduct. However, psychological research has been no more successful than physicalist research in establishing the existence of psychological attributes which can explain, or are consistently associated with, psychopathy (see e.g. Black 1966). Psychologists have even failed - once again as they themselves admit - in their attempts to construct psychological tests which are capable of distinguishing

the psychopath from the non-psychopath, or of confirming whether or not a particular individual is a psychopath.[5]

However, even if tests were devised which were accepted as reliable instruments for discriminating between the psychopath and the non-psychopath, these would still not prove the existence of a definite mental state called psychopathy. We have to ask ourselves what such tests could actually tell us. Those tests which have been used were intended as 'ethical tests' or 'temperament tests' (Watson 1988). Their purpose was to discriminate between those with normal social sentiments and those with abnormally anti-social sentiments. All that such tests could prove is that those who fail them have anti-social attitudes. Even if successful temperament tests were devised, the most they could do would be to 'detect' those with an anti-social disposition. There are no good reasons for presuming, however, that those whose attitudes are *judged* to be anti-social share any special physical, genetic or psychological attributes. Attitudes are not inherently social or anti-social, rather 'anti-social' is an evaluation which we attach to attitudes (and to conduct). Similarly the concept of psychopathy is not simply a descriptive concept, it is also a judgemental concept.[6] As such, psychopathy is not something which can simply be discovered.

It is misleading to refer to the "discovery" of psychopathy, as if 'psychopathy' is a tangible object which has always existed but was not known to us until it was revealed by medical or psychological science. Instead, we need to think of this phenomenon simply as a change in the way of *interpreting* the behaviour and attitudes of those who persistently, and without remorse, act in an anti-social manner.

Such people might always have existed, but to name them psychopaths is to *change* their meaning for us. This change in the way of perceiving such characters needs to be explained. We need to know why it occured and, most importantly, we need to ask what were the distinctive features of this new perception of anti-social characters? Conventional accounts of this development fail to provide adequate answers to these questions. In a sense they avoid these questions by presuming that psychopathy is a constitutional condition which was simply 'discovered' in medical or psychological laboratories. I will argue, to the contrary, that 'psychopaths' were not simply 'discovered', rather they were re-named, re-described, and ascribed with a new significance. This process of re-naming, re-describing and re-interpreting 'psychopathy' was not inevitable. We need to understand why this approach to psychopathy emerged, rather than some other approach. And we need to know what was distinctive about this new way of naming, describing and understanding the psychopath. The answers to these questions cannot be found by looking at developments in psychiatric ideas and knowledges in abstract. Rather it is necessary to look at the penal and social discourses within which this process of naming, describing and interpreting the psychopath took place.

The arguments of sociological sceptics are also not very helpful when it comes to understanding the formation and development of the concept of psychopathy. One of the major contributions of sociological sceptics to this debate is to argue that medical designations of deviance - such as 'psychopathy' - were the product of political

battles between medicine and law over 'social-control turf' (e.g. Conrad and Schneider 1980). This argument, like conventional accounts of the formation of the concept, makes the mistake of presuming that the formation of the category of psychopathy can be understood simply as the product of a shift towards a medical interpretation of a anti-social conduct. However, while conventional accounts regard the medical perception of 'psychopathy' as 'true', this argument regards the medical interpretation as having no scientific basis. Conrad and Schneider (1980: ch.10), for instance, regard the shift from legal to medical designations of deviance as a political, rather than a scientific achievement. In other words, it was the political power and social prestige of the medical profession, rather than the veracity of medical theories, which allowed medical designations of deviance to gain social and political acceptance. But why should the medical profession want to medicalize deviance? Conrad and Schneider's answer is that medicalization of deviance facilitated medical expansion - at the expense of law - into the field of social control. This, they argue, was profitable to the medical profession since it allowed them to colonize the field of social control, thereby reaping the profits to be made from working in this area. But medicalization of deviance was also useful for governments - who therefore supported the medical profession in this battle over social control turf - since it helped to legitimize the social control of delinquents, such as psychopaths, who could not be adequately controlled through the mechanisms of law and because medical techniques appeared to be more successful than punitive techniques in achieving social control.[7]

In the account which follows I will accept that the legal recognition of the category of psychopathy was at least partly the product of a political struggle. It could hardly have been otherwise since even if the category of psychopathy did have a firm foundation in scientific knowledge, this would not have guaranteed its political acceptance. However, I will argue that it is wrong to characterize this struggle as being between medicine and law. Although psychiatrists did play a major role in the debates over the concept of psychopathy, their relationship to legal and penal agents was far more complex than the adversary one suggested by the medicalization thesis.

ADMINISTRATIVE CATEGORIES AND PSYCHIATRIC CONCEPTS

The term psychopathic personality was not used in practical penal discourses in Britain until the 1920s. The term 'psychopathic inferiority' had, however, been used in psychiatric discourse in the late nineteenth century, most notably in the work of the German psychiatrist Kraepelin (Official Publications 1975: para. 5.6). Kraepelin's concept of psychopathic personality is described, by the Butler Committee, as being influenced by the idea of hereditary degeneration and by Lombroso's concept of 'the born delinquent' (ibid: paras. 5.5-5.6). We should not presume, however, that the penological concept of psychopathic personality - by which I mean the concept which was employed in penal discourses in Britain from the 1920s - was derived from Kraepelin's concept. Nor should we presume that it was derived from the degeneration theories of French psychiatrists such as Morel, or from the criminal anthropology of Lombroso, even though the ideas of Morel and Lombroso had been disseminated in Britain through

the writing of Maudsley and Ellis (see ch.6). I will argue, contrary to such presumptions, that the term psychopathic personality was adopted in penal discourse in Britain, not so much out of theoretical commitment to the ideas of moral degeneration and the born criminal, but mainly because it was a convenient way of designating a category of offenders which had already been partially defined, by prison administrators, since the 1870s.

This is not to say that the penological category of psychopathy was purely an administrative category, formed without reference to developments in psychiatric theory. To the contrary, prison doctors, who were often quite cognizant of developments in mental medicine, played a major role in prison administration from the 1870s on.[8] These prison doctors undoubtably brought psychiatric ideas to bear upon administrative problems. It is therefore not possible to draw a sharp distinction between the administrative categories of the prison and psychiatric categories, during this period. Even more importantly, however, this relationship worked both ways. The concerns of prison administration (along with the concerns of the managers of other social institutions, such as schools) - had a profound influence the development of psychiatric categories. The administrative concerns of penal and other social institutions not only provided the context within which many psychiatric categories were formed and developed, these practical concerns also influenced the definition of psychiatric categories. It is therefore necessary, in order to understand these psychiatric categories, to refer to the institutional context in which they emerged.

THE FEEBLE-MINDED

In order to understand the formation of the penological category of psychopathy it is necessary to examine the formation of a two closely related categories: 'the feeble-minded' and 'moral imbeciles'. I will look first at the problem of the feeble-minded. In the late nineteenth century the term feeble-minded was used to designate those who, although not mentally deficient enough to be certifiable under existing lunacy laws, were nevertheless considered to be so weak-minded as to be beyond socialization and education (Rose 1985: 99).[9] At the time there was no special legal or institutional provision for the feeble-minded, a 'gap' in social provision which social reformers were eager to fill (see Jones 1972: ch.8). One of the main reasons for this lack of provision was that, until this time, those who were now regarded as 'feeble-minded' had been regarded *by the law* as ordinary citizens who were no different from others in their essential characteristics, and for whom special legal and institutional provision was neither necessary nor justifiable.

Special legal provision *did* exist for mental defectives - who were regarded as lacking reason and free will, the essential characteristics of citizenship - but the 'feeble-minded' were not included in this category. When doctors and social reformers talked of the mentally defective, they were usually referring to idiots and imbeciles, i.e. persons with severe intellectual disorders, often accompanied - at least in the case of idiots - by physical defects (Rose 1985: 94-7). Since the 'feeble-minded' were not *severely* disordered intellectually, and since they did not display any obvious physical defect, they were generally not considered as belonging in

the same category as mental defectives. In fact, until the second half of the nineteenth century the category of the feeble-minded was neither self-evident nor theoretically established. It was only in the late nineteenth century that doctors and social reformers started to regard the feeble-minded as a special category requiring special legal provision and special forms of intervention. The category of the feeble-minded only became conceivable as a result of complex developments in social institutions and psychological theory.

Here I will concentrate upon the developments in social institutions which helped make the problem of the feeble-minded conceivable. This is not because these developments are more important than theoretical developments in explaining the formation of social or psychiatric categories. Rather, as I have indicated, it is because the theoretical developments which led to the formation of the category of the feeble-minded did not occur independently, but were intrinsically linked to developments in social institutions (cf. Rose 1985: ch.4). Psychiatric theorising about the feeble-minded was not done in abstract, but was both prompted and shaped by the problems which certain forms of 'undesirable' conduct posed for recently established, or recently transformed, social institutions. The problem of the feeble-minded emerged in a number of institutions (ibid: 98). Here I will look very briefly at the problem is schools, where it emerged most forcefully (ibid), before considering the problem as it emerged in prisons.

Schooling and the feeble-minded

In the last third of the nineteenth century, schooling in Britain underwent a major expansion, while at the same time there was a

transformation in its organisation and its objectives. First, schooling had been transformed by the establishment of universal, free and compulsory, elementary education (ibid: 98-111). Secondly, there was a related development in which the objectives of schooling had become more 'secularised'; whereas schools had previously been regarded primarily as agencies of moralisation, their main function was now being increasingly defined as the transmission of literacy and numeracy (Jones & Williamson 1979). To be more precise, schools were still seen as having a moralizing function, but this was to operate indirectly, by training children in the basic skills of reading, writing and arithmetic - thereby enabling their future participation in other social institutions - rather than by direct moral instruction and moral training (ibid).[10]

As the universal schooling network became established it soon became apparent that some children were 'beyond education', or, in other words, incapable of learning the lessons of the school. Certain children were obviously beyond ordinary education, such as those with severe sensory defects - the blind, the deaf and dumb (Rose 1985: 99) - and those with severe cognitive defects, i.e. idiots and imbeciles. However it soon became apparent that there were pupils who were not obviously defective - physically or mentally - but who were nevertheless beyond ordinary education. As Rose puts it: ". . . there were also rapidly found to be children who, while apparently fully provided with their complement of senses, appeared unable to learn the lessons of the school" (ibid). These children were referred to, in official discourse, as 'educational imbeciles' and as 'feeble-minded' (ibid).

And we might also note that being 'beyond education' meant not only being unable to do schoolwork because of intellectual weakness, but also being incapable of learning because of an inability (or unwillingness) to obey the disciplinary demands of the school (see Rose 1985: 102). In modern terms, the category encompassed all those with learning difficulties, whether these were the product of low intelligence or of behavioural problems. These educational imbeciles were deemed to require separate and special schooling, both for their own benefit and to prevent them from interfering with the smooth functioning of the ordinary schoolroom (Rose 1985: ch.4).

So, as a specific category, the feeble-minded only came into being with the emergence of a new (or recently transformed) social institution, which made new demands upon children. These demands led to the construction of new social categories consisting of those who were unable to meet these demands. The category of the feeble-minded was not a product of abstract psychiatric theorising; rather it was largely an administrative category which was represented in psychiatric terms.

Prisons and the feeble-minded

Like the education system, the prison system had undergone a major expansion by the 1870s. The transportation of convicts had come to an end, the use of corporal punishments had greatly declined, and incarceration - particularly in prisons - had become the central mode of punishment for adult offenders (Garland 1985: 7). At the same time prisons began to adopt a much modified version of the 'separate system' of prison discipline.''

The separate system, which was introduced in Pentonville in the 1840s (Ignatieff 1978), was described by J. B. Thomson - who was the Resident Surgeon at the General Prison for Scotland - as follows. In its pure form:

> . . . the prisoner was strictly confined to his cell, which was his workshop and dormitory. He had little or no communication with officers. The exercise was short, and in isolated cages under absolute silence. A mask was worn to avoid personal recognition. The chapel was cellularly divided; or the chaplain stood in the corridors of a gallery, each prisoner only hearing, not seeing him, through the cell-door upon the bolt. The food was passed through a small service door, so that even the warder was not seen. (Thomson 1867)

This system was often criticised - particularly by advocates of its rival, the 'silent system' - as having deleterious effects upon the prisoner (see e.g. Bucknill 1857; cf. Rothman 1971). Instead of improving offenders, it was argued, the separate system left prisoners weakened mentally and physically, and often led to insanity and other nervous disorders (Bucknill 1857: Thomson 1867).

> . . . at the end of his sentence the individual emerges etiolated in mind and body. The man, perhaps, is weakened for harm, but he is not strengthened for good. (Bucknill 1857)

Partly in response to such criticism, the separate system was modified at Pentonville and when it was introduced into other prisons it appeared in a much modified form. In particular, certain categories of offender, who were considered unfit to bear the separate system, were allowed to associate. In the modified separate system:

> "After a confinement of nine months male convicts, and after twelve months female convicts are partially associated. Exercise is had more freely in open airing-grounds. The chapels are not cellular, but open seated. Masks are abolished. Warders see and speak to prisoners at least twelve times daily. Silence is not strictly enforced; *and medical officers have free power to associate all those who are regarded as unfit to bear the separate system: such as juveniles, epileptics, weakminded, and suicidals, Highlanders who cannot speak English, and all the sick*"
> (Thomson 1867, emphasis added)

It was in this context that the 'weakminded' began to be constructed as a specific category of offenders. The weakminded were those who although not obviously insane or mentally defective enough to be transferred to a lunatic asylum, were nevertheless considered unable, due to mental deficiency, to bear the rigours of prison discipline. Once again it was the demands which social institutions made upon certain groups, and the inability of certain individuals within those groups to meet those demands, which led to the construction of a new social-psychiatric category.

There was a complication in the case of the prison however, because to treat some categories of prisoner differently from others would be to defeat another penal objective, itself considered essential to good prison discipline, i.e. the objective of uniformity of treatment (see Garland 1985: 13-14; Gunn et al 1978: 9). In order to ensure uniformity, while at the same time maintaining a harsh disiplinary regime, it became necessary to transfer those who were unfit for penal discipline to other institutions (Gunn et al 1978: ch.1). Hence prison officials eagerly advocated and supported proposals to establish alternative, quasi-penal, institutions such as juvenile reformatories and inebriate reformatories. As we have seen in the case of inebriate reformatories, these were considered necessary for the better reformation and exclusion of special categories of offender; but just as importantly, they were also seen as necessary to ensure that ordinary prisons could perform their function of disciplining and punishing ordinary criminals (ibid). This was clearly stated in 1908 by H. Smalley, the medical inspector of prisons:

> . . . the greatest difficulty in the way of the rational treatment of the criminal is due to the fact that he has to be dealt with by the

> same methods, and in the same class of institutions as the various quasi-criminal groups with whose characteristics he really has very little in common. The cleaning out from our prison of the drunkard, the tramp and the imbecile (would at long last enable) prisons to be used for the treatment of the criminal.
> (cited in Gunn et al 1978: 11; cf. Watson 1988)

The establishment of special institutions for criminal lunatics, had already helped prisons to rid themselves of those with gross mental abnormalities (Gunn et al 1978: ch.1). The establishment of reformatory and industrial schools in the mid-nineteenth century prevented juvenile delinquents from being sent to prison (see Rose 1985: 166-68). And as we have seen, the inebriate reformatory programme - which aimed to divert habitual drunken offenders from prison - was moving towards realization in the late nineteenth century. Attention then shifted to adult offenders who were neither lunatics, nor idiots, but were nevertheless considered to be weakminded enough to require protection from the rigours of penal discipline. Eventually the term 'feeble-minded' was used to designate such offenders (Gunn et al 1978: 7-11).

From what has been said it should be clear that the category of the feeble-minded was not imposed upon penal discourse from outside. In the first place many penal officials actively supported the proposals of those psychiatrists who argued the need for special legal and institutional provision for the feeble-minded (Gunn et al 1978: ch.1). The removal of these disruptive elements from ordinary prisons would allow the prison to function more smoothly, enabling it to get on with what many regarded as its 'proper' function, the disciplining and punishment of ordinary criminals (ibid). Secondly, as we have just seen, the prison was one of the institutional sites where feeble-

mindedness became constituted as a psychiatric problem; the prison acted as a practical 'surface of emergence' for the new categories of mental deficiency - such as feeble-mindedness and moral imbecility - which were being developed.[12]

The significance of the feeble-minded

With the formation of the category of the feeble-minded, another social category - the category of 'mental defectives' - was both expanded and transformed. The category of mental defectives, which had previously consisted of idiots and imbeciles who had severe cognitive defects, was expanded to include the feeble-minded, who were not severely mentally defective but merely mentally *deficient*. Just as importantly, with the formation of the category of the feeble-minded the category of the 'mentally deficient' was no longer associated solely with cognitive disorders, but encompassed disorders of character and conduct as well. With the higher grades of mental deficient - such as the feeble-minded - mental deficiency was inferred less from lack of cognitive ability and more from undesirable attitudes and conduct.[13] The feeble-minded were defined, not so much by reference to lack of cognition, but by reference to their *social incompetence*.

In the category of moral imbecility this tendency, which was already established, was simply taken a step further. The moral imbecile - as we saw in the previous chapter - was regarded as having normal, or even above normal, intellectual powers, but as being 'morally defective'. In the case of the moral imbecile, mental deficiency was inferred solely from undesirable conduct and attitudes.

The category of the feeble-minded was of crucial importance then as a mediating category between those categories, such as idiocy, which encompassed purely cognitive defects, and those such as moral imbecility, which denoted disorders of the affections and conduct without intellectual defect. The category of the feeble-minded provided the link between cognitive and moral defects, allowing both to be presented as different types of mental deficiency. As I will argue in a moment, the linking of moral defects with cognitive defects was further facilitated by the fact that the feeble-minded were often not distinguished from 'moral incapables'. It was only with the passing of a the Mental Deficiency Act, 1913 that a a sharp distinction between the two categories became firmly established.

MORAL INCAPABILITY, MORAL IMBECILES AND *THE ROYAL COMMISSION ON THE CARE AND CONTROL OF THE FEEBLE MINDED*

The concern with the problem of the feeble-minded eventually led to the appointment of a Royal Commission to inquire into the problem. The Royal Commission on the Care and Control of the Feeble-Minded (also known as the Radnor Commission) is regarded as important in histories of the mental health services, on the grounds that it undertook a major investigation of the problem of the feeble-minded and recommended major changes in law so that this newly 'discovered' group of 'mental deficients' - along with closely related groups such as moral imbeciles - could be provided for adequately (see Jones 1972: ch.8.). In such accounts it is recognised that the commission's report was also of some relevance to penal issues, since the feeble-minded, because of their condition, often became criminals. As The National

Association for the Care of the Feeble-minded - which campaigned for legislative enactment of the Radnor Commission's recommendations - put it: because of the neglect to recognize and treat their condition, "the mentally defective become criminals and are sent to prison; they become drunkards and fill the reformatories . . ." (quoted in Jones: 1972: 196).

Here, I will look at the Radnor Commission from a somewhat different angle. I will argue that its concern with penal matters was not merely incidental, rather it was central to the commission's investigation. The main object of investigation for the commission was a penal-social problem, and its recommendations were *directly* concerned with the scope and objectives of the penal system. The Radnor Commission's proceedings should be understood as penal discourse, and not as psychiatric discourse which happened to be relevant to penal affairs. This is important since the Commission's recommendations led to legal recognition of the category of moral imbecility, and indirectly, to the formation of the penological category of psychopathy.

One way of establishing what the commission's main concerns were is to look at the way in which it employed key terms such as feeble-mindedness and moral imbecility. Many of the witnesses before the Royal Commission hardly distinguished between these two terms, using them - and others such as 'weak-minded' and 'morally incapable' - as if they were interchangeable. Even in the report of the commission the two categories were not consistently distinguished. This might be partly explained by suggesting that the distinctions which were being made by the leading psychiatric theorists of the day were not full appreciated or understood throughout the profession.[14] More

importantly though, many of the witnesses and members of the commission were not medical professionals at all. Educators, penal officials, reformatory managers, poor law officials, lawyers, and private philanthropists were among those who contributed to the proceedings, whether as witnesses or as members of the commission (Official Publications 1908b: Jones 1972: 191). For these, and for many psychiatrists, the theoretical distinctions between the two categories were not of vital importance. The theoretical distinction between the feeble-minded and moral imbeciles was made in terms of their psychological differences - moral imbeciles were more intelligent than the feeble-minded. But in terms of the practical problems they presented - for government and for the managers of penal and educational institutions - there was little difference between the feeble-minded and moral imbeciles. And it was with these practical problems that the commission, and most of the witnesses, were primarily concerned.

From reading the Radnor Commissions proceedings it becomes clear that - despite claims to the contrary - its main concern was with the moral incapability - i.e. the social misconduct and incompetence - of the 'mentally defective', rather than with any mental condition which they shared.[15] The commissions's stated concern was with the large numbers of; -

> . . . mentally defective persons whose training is neglected, over whom no sufficient control is exercised, and whose wayward and irresponsible lives are productive of crime and misery, of much injury and mischief to themselves and to others, and of much continious expenditure wasteful to the community and to individual families. (Official Publications 1908b: para.9)

It was the social problem which these persons created, rather than their mental condition as such, which caused the commission concern. The person who remained within the law, behaved responsibly, didn't create mischief or injury, and didn't become an economic burden upon their families or the State, was of no concern to the commission even though they might be of exceptionally low intelligence. Conversely, once one persistently acted in an irresponsible manner, committing crimes and other mischief, and became a financial burden, they were regarded as requiring social intervention, even if they were of normal - or even above normal - intelligence. Persistently delinquent and irresponsible persons could be designated feeble-minded if their delinquency was accompanied by low intelligence. But if there was no sign of low intelligence or cognitive defect they could still be designated moral imbeciles, and hence as belonging to the wider category of mental deficients. Although the feeble-minded and moral imbeciles might differ in their mental attributes, the latter being more intelligent than the former, the problem they posed was the same: the conduct of both was widely regarded as undesirable and unacceptable, but neither was certifiable under existing law. The following paragraph shows the commission slipping between the morally incapable and the weak-minded, as well as revealing its main concern with 'social danger':

> There are undoubtably numbers of persons who are not idiots or lunatics, or at least are not regarded as either - persons of weak mind who are socially dangerous. In the affluent classes there are numbers of weak-minded lads. I have known murders perpetrated by lads of that character, who are not thought to be certifiable, but allowed to go about uncertified though obviously weak-minded. Among the poorer classes, there are, no doubt, great numbers of morally incapables who are not certified, and who are moving about and are socially dangerous. (Official Publications 1908b: ch.23)

The Radnor Commission's recommendations

The commission recommended that moral incapables (and the feeble-minded) should be subject to the same form of social control as lunatics and idiots. It was argued that even though moral imcapables were not, strictly speaking - insane, they were not fully responsible either. Because they lacked full responsibility, moral incapables constituted a social danger; just as the insane would if they were not subject to social control. In this respect - i.e. in respect of the social threat which they constituted - moral incapables were no different from outright lunatics. It was therefore logical to extend the precedent established in the lunacy laws to the control of all those who, due to weak-mindedness, were a threat to society.

> There are cases where weak-minded persons commit crimes, and they are not certifiably insane. They cannot, strictly speaking, be found insane under the law as laid down in MacNaghten's case, or under the law as ordinarily administered, and yet they are from weakness of mind really not wholly responsible. You cannot say that they are insane, and yet the state of their minds is such that they ought not to be set at liberty and allowed to commit further crimes of the same sort. . . .
>
> We find therefore - and there is evidence in regard to it from all quarters - that, while there is a large class of mentally defective persons who are certified as lunatics, and can thus be detained and receive the protection of the state, there is also another large class of persons who can often be hardly distinguished from the 'certifiably insane', who are 'morally incapable' 'socially dangerous', and 'obviously weak-minded' who are 'not thought to be certifiable' and who 'from weakness of mind are not wholly responsible'. 'Lunatic' according to the Lunacy Act of 1890, 'means an idiot, or person of unsound mind'; and a person found to be in that condition is legally recognised as irresponsible. Questions arise accordingly, whether the condition of being irresponsible should not attach to other mentally defective persons besides certified lunatics. (Official Publications 1908b: paras. 436 & 437)

There is the rhetorical suggestion here that moral incapables and the feeble-minded are a little insane. But it should be stressed that this did not amount to saying that moral incapables and the feeble-minded

were in fact insane. To the contrary, a distinction was maintained between the insane, on the one hand, and moral incapables and the feeble-minded on the other. The argument was that moral incapables and the feeble-minded shared certain features with the insane - and in particular their social incompetence and dangerousness - and that they should therefore be subjected to social control, as were the insane.

It was also pointed out that special forms of control were exercised over inebriates, and that these also constituted a precedent for control over moral incapables and the feeble-minded. This was of crucial importance since - as I have suggested - inebriates, like moral incapables and the feeble-minded, were subject to special forms of control because of their conduct, rather than because of any proven cognitive defect, while at the same time there was a rhetorical suggestion that inebriates were a little mad - a suggestion which helped get the inebriates legislation passed.

> At present, if we omit the procedure adopted in the case of the insane and in that of the habitual drunkard, there is no form of procedure available for other classes of mental defect - other classes of the 'uncertifiable'. The insane, as we have seen, may be kept under detention as King's Pleasure lunatics or Secrtetary of State's lunatics; and the habitual drunkard may be sent to reformatories for any period not greater than three years; but for the imbecile or feeble-minded or the moral imbecile there is neither recognised procedure nor available institution.
> (Official Publications 1908b: para. 458)

What was ignored here was the fact that, just a few years earlier, special controls for the inebriate were justified on the grounds that the inebriate was a special case. The commission also failed to acknowledge that the inebriate reformatory programme was highly controversial; its legitimacy was by no means firmly established at

this stage. Instead the commission presented the control of inebriates as ordinary and quite legitimate and argued for a further extension of such control.[16]

The inebriate reformatory experiment was seen as a precedent in a practical, as well as in a legal, sense. The inebriate reformatories were advocated as models for the proposed mental deficiency institutions. The architecture of the reformatories, their mode of administration, and the regimes within inebriate reformatories were all seen as suitable for institutions for the feeble-minded and moral imbeciles.[17] So, as was the case in the inebriate reformatory experiment, the objective of the Royal Commission was not simply to establish institutions for the detention and segregation of moral incapables, these institutions would also be places of 'treatment'. And when the commission talked about the 'treatment' of the feeble-minded and moral imbeciles as 'patients', what they actually had in mind was reformatory discipline and moral treatment rather than medical treatment.[18] Moral imbeciles and the feeble-minded were to be taught to lead 'useful lives', which involved them in activities such as learning trades or being employed in the farm or garden (Official Publications 1908: see q. 6937).

There was one respect, however, in which the legal status of moral incapables and the feeble-minded was to remain different from that of the insane. Moral incapables were to be held legally responsible for any crimes which they committed. The insanity defence was to remain available only to those found to be insane according to the restrictive, intellectualistic definition of insanity contained in the

M'Naghten Rules. A diagnosis of moral imbecility was not to effect legal verdicts; it would only become relevant after the legal issue of the accused person's guilt had been decided by the criminal court, according to strictly juridical criteria. Only after the verdict was announced would the question of moral imbeciltity be raised, in order to determine what was to be done with the moral imbecile-offender.

> . . . in the case of persons who are charged with offences and are alleged to be mentally defective the principle should be adopted of keeping the question of the committal of the alleged offence separate from questions of the alleged mental defect, the relative responsibility of the offender and his appropriate treatment when charged with crime or convicted.
>
> It is not . . . necessary or desirable that the precedents under the Trial of Lunatics Act, 1883 . . . should be pushed further. . . The question of fact may go to the jury, and when that is settled, the question of mental defect may be settled by the court in modification of the sentence.
> (Official Publications 1908b: paras. 26 & 460)

There was, of course, a logical contradiction here: on the one hand it was being argued that moral incapables and the feeble-minded, due to weak-mindedness, lacked full responsibility, while on the other hand it was being asserted that they should be held fully responsible for any crimes which they committed. The commission acknowleded this contradiction but argued that it would be "inexpedient" for the courts to recognise a concept of diminished responsibility and that moral incapables and feeble-minded persons must therefore be held legally responsible for their crimes (ibid: para.458).

> It is of course true . . . that a person must be either responsible or irresponsible; that in the matter of criminal procedure these two terms cover the whole ground, and that where the question is 'guilty or not guilty' it would be impossible for the law to admit the existence of any doubtful territory between the two.
> (Official Publications 1908b: para.458)

The problem was represented as a practical one: juries were not competent to determine whether or not a person was a moral imbecile. Whereas the lunatic and the idiot could be clearly recognised by the layman, the differences between the moral imbecile and the normal person could be detected only by medical experts who had observed the offender over a period of time and who were familiar with the history of the case (ibid: para.459). We can recall Prichard making a similar point - with regard to moral insanity - two generations earlier (see ch.5), But whereas Prichard concluded that this demonstrated the need for medical experts in the criminal court, the commission were now arguing the opposite: that the criminal trial would have to remain an exclusively legal affair, with questions about the offender's mental capacity being restricted to the traditional ones of whether he was a *total* lunatic or an idiot. Prichard's conclusion seems just as logical - if not more so - as that of the commission. And, in any event, the question of whether an offender was a moral imbecile would have to be addressed at some stage - i.e. between the verdict and the sentence - and the commission saw no problems in answering the question then. I would argue therefore that the practical problems involved in distinguishing the moral imbecile from the normal person cannot explain why the commission proposed to leave the moral imbecile's legal responsibility intact.

The more likely explanation for the commission's standpoint on this issue is that it was - perhaps without conscious intention - making a tactical compromise. The radical attacks upon criminal justice, and in particular upon the legal concept of responsibility, - mounted by criminal anthropologists and some psychiatrists in the second half of

the nineteenth century - had met with little political success and had in fact encountered much hostility (cf. Nye 1984: ch. 4; Garland 1988). The commission's proposal was more compromising, and likely to meet less resistance. Its proposals would leave most questions concerning crime within the judicial domain, while establishing a limited role for psychiatry within the penal process. More specifically, the question of guilt or innocence would retain its central importance in the penal process, and would be determined according to strict legalistic criteria, while the degree of punishment meted out would no longer be restricted by the principle of proportionality but would be modified on the basis of psychiatric criteria.

So what was being proposed was not the total replacement of punitive justice with psychiatric social control. Rather, a more modest suggestion was being made: that psychiatry work alongside punitive justice, modifying punitive justice to some extent, but leaving the basic framework intact. The nineteenth century battle between psychiatry and 'law' was to be resolved, with psychiatry having gained some ground, but 'law' remaining the typical response to delinquency. Perhaps even more importantly, a mutually beneficial working relationship would emerge, in which psychiatry would relieve the prisons of troublesome cases, and justify the control of those whose detention and segregation could not be legitimated in purely punitive terms, while the penal system provided psychiatry with new objects to study and treat.

THE MENTAL DEFICIENCY ACT, 1913

A Mental Deficiency Act, incorporating the recommendations of the Radnor Commision, was passed in 1913. The provisons of the act covered idiots, imbeciles, feeble-minded persons, and moral imbeciles. Moral imbeciles were defined as -

> persons who from birth or from an early age display some permanent mental defect, coupled with strong vicious or criminal propensities, on which punishment has had little or no deterrent effect. (Mental Deficiency Act, 1913, section 1 (d)).

The first thing to note about this definition is that moral imbeciles, like the feeble-minded, were defined by reference to their failure to meet the demands of particular institutions. Penal institutions were charged with the task of reforming and deterring delinquents. Those whom penal institutions could neither reform nor deter were regarded as beyond penal control and defined as moral imbeciles (cf. Garland 1985: 224). Accordingly, it was one's 'career' in correctional institutions - or one's 'moral history' - rather than any observable or objectively verifiable physical or mental condition, which was to be the crucial factor in determining whether one was a moral imbecile.

Interpretations of 'moral imbecility'

The second point about this definition of moral imbecility is its potential ambiguity. The definition fails to make it clear whether those without any defect of intelligence were to be considered as moral imbeciles. As Burt put it in *The Young Delinquent*:

> The words may mean, first of all, one who is primarily defective in intelligence, but happens, in addition, to possess an incorrigible propensity to crime, a propensity itself independent of, and superimposed upon, the essential defect of intelligence. But secondly, the clause may bear, almost equally well, a totally different sense: it may denote a person whose incorrigible

> criminality is of itself enough to constitute, or is itself the necessary result of, an inborn mental defect. With the former meaning, by a curious paradox of legal grammar, a moral imbecile would be an imbecile whose behaviour is not moral; with the latter he would be an intelligent person whose morals are imbecile. The difference is plain. The one is an immoral defective; the other is defective morally" (Burt 1944: 31)

Or rather the difference was plain to Burt. As I have suggested the theoretically established difference between feeble-mindedness (which implied some intellectual defect) and moral imbecility (which implied no intellectual defect) was not appreciated by all practising psychiatrists and other social policy makers, who often used the terms as if they were interchangeable.

As Burt points out, the second interpretation (the moral imbecile as defective morally) appears most logical (ibid). If the term 'moral imbecile' was intended to refer to 'an imbecile whose behaviour is not moral' there would be no practical need for a separate category of moral imbecility. The so-called 'moral imbecile' would in that case fall into one of the other categories of mental defect recognised by the Act, such as 'the feeble-minded'. And indeed, in theoretical discussions, the tendency was to adopt the second interpretation.[19] However, as Burt points out, in practice, the former interpretation was generally adopted (ibid). Burt's point was later corroborated by the *Royal Commission on the Law relating to Mental Illness and Mental Deficiency, 1954-57*:

> "Many doctors, probably the majority, never make a diagnosis of feeble-mindedness or mental defectiveness whether the patient's personality is predominantly aggressive or inadequate, unless the patient shows some limitation of intelligence or has a history of having been regarded as educationally subnormal or backward in childhood" (Official Publications 1957: para. 177)[20]

The source of the ambiguity lay in the fact that the concept 'mental' was at the time a contested concept, and so therefore was the concept 'mentally defective'. And, of course, the attempt to include 'moral imbeciles' among the mentally defective was a key struggle within this wider contest. Two opposing positions can be identified:
(i) the restrictive definition of 'mental':- this identified the term 'mental' solely with the intellect; so to say that somebody was mentally defective was the exact same as saying they were intellectually defective.
(ii) the broader definition: this defined the term mental broadly, to include the moral faculties as well as the intellectual faculties. To be mentally defective could mean either being defective intellectually or defective morally (or both) According to this definition: "Mental defect is a disorder of the mind, but not necesarily a disorder of the intellect. A defective may be extraordinarily intelligent, even clever in some ways" (Police Orders 1921).[21]

Confusion between these two positions appears to have been caused by adherents to the first position regarding their definition of mental as 'inevitable', as the only right or rational way to define mental. For those used to thinking of the mental solely in terms of intellect, any other conception was difficult to comprehend. So, in order to avoid ambiguity, those who wanted special provision for moral imbeciles would have to have argued that those who were defective morally were to be subject to special powers even if they were not mentally defective. However, while this would have avoided ambiguity, it would have meant accepting the restrictive definition of mental; it would have meant acknowledging that the concept mental referred solely

to the intellectual faculties. But, as we have seen, there were both theoretical and tactical reasons for challenging this restrictive definition. Ambiguity was therefore unavoidable.

The practical result of this was that the designation 'moral imbecility' was rarely used, and even when it was used, it was applied was those who were regarded as suffering from some sort of cognitive defect, in addition to having vicious or criminal propensities (Gunn et al 1978: 14-15). But logically, these cases could have been dealt with as feeble-minded persons, or even as imbeciles. In practical terms, the provision for moral imbeciles was almost redundant.

This would mean that the Mental Deficiency Act had failed, in practice, to make provision for those who were intellectually normal, but who were nevertheless regarded as defective morally. That is to say, even after the Mental Deficiency Act, 1913, there was still no special legal and institutional provision for the 'moral imbecile', strictly defined. So, although there was a reform programme which had the objective of creating special legal and institutional provision for the administrative control of moral imbeciles, and although this programme was translated into legislation, the programme was, nevertheless, not realised in practice at this stage. The opposition between 'those with understanding' and 'those without understanding' had been reasserted as the only basis, in practice, for the classification of delinquents. As Gunn et al have stated:

> . . . the Act relieved the prisons of the seriously subnormal offender. By 1929 the Medical Commissioner estimated that its provisions had reduced the daily average prison population by about 200. But in respect of one sub-group, the prison authorities were less fortunate. 'Moral imbeciles' had been brought within the compass of the 1913 Act in response to evidence given to the Royal Commission by prison (and other) doctors. The former must have rejoiced that these particularly difficult offenders were now to be

> channelled into the new asylums. But this first attempt to deal with one group of psychopaths was ahead of its time and was rarely used. Doctors came to believe that in order to come within the terms of the Mental Deficiency Acts, the moral defective had also to display defective intelligence. The Act was therefore mainly used for those cases where moral defectiveness was coupled with subnormal intelligence. (Gunn et al 1978: 14)

THE FORMATION OF THE PENOLOGICAL CATEGORY OF PSYCHOPATHY

Those who wanted special legal and institutional provision for moral imbeciles - i.e. persons of normal or even extraordinary intelligence, whose conduct was defective - had witnessed the passing of legislation which appeared to make such provision. Once the legislation started to be acted upon (in the 1920s, due to the disruption of war) they saw the term moral imbecile being interpreted in a somewhat perverse, restricted way, so that the 'true' moral imbecile was excluded. It was at this stage that the designation 'psychopath' began to appear frequently in penal discourse. The term was applied to the 'true' moral imbecile, partly in order to distinguish him from those who had come to be regarded as moral imbeciles (i.e. those whose defective conduct was accompanied by intellectual defect). A fresh attempt was being made to construct a category of delinquents who were to be considered distinct from ordinary delinquents in terms of their pathological conduct and attitudes, rather than in terms of their lack of understanding.

The term 'psychopathy' was adopted by penal practitioners for its practical covenience - and also, no doubt, for its 'medical sound' - rather than because of theoretical commitment to the term. In fact the term was originally regarded as unsuitable and inappropriate, but it was adopted nonetheless as a convenient term for describing a category

of offenders who had nothing in common psychologically (other than their lack of any obvious intellectual defect), but who nevertheless posed a distinct problem for penal administration.

These claims can be supported by considering the Howard Journal's discussion of the Report of the Prison Commissioners for 1924-25 (Howard Journal 1926: 38-44).[22] The major theme of this report was the prison's failure "in a task which it should never be set to, i.e. dealing with the mentally unfit" (ibid). Mentally unfit persons were still being sent to prison, it was argued, despite the Mental Deficiency Act 1913 and the subsequent establishment of Mental Deficiency Institutions. The Mental Deficiency Act had eased the problem, but it had not resolved it.[23]

Three reasons were given "for the continued presence of the mentally defective in our prisons" (ibid). First there were difficulties in finding institutions to take cases; the construction of more institutions was recommended. Secondly, it was often difficult to prove that mental defect had existed from birth or from an early age; it was recommended that the legislation be amended to remove this requirement. The third problem is the one which concerns us here. It was argued that there were many prisoners who were abnormal - as evidenced by their chronic inability to remain within the law - but who were not regarded as certifiably mentally deficient. This was, in effect, a restatement of the 'moral imbeciles' problem, with the crucial differences that the term moral imbecile was no longer used. For this group of quasi-mental deficients, some new form of non-penal detention was required; something more than - and other than - the determinate sentence justified by their offence, but something less

than the indeterminate detention considered justifiable in the case of certifiable mental deficients.

> There are a great many abnormalities which would not alone justify a certificate of lunacy or of mental deficiency. It would be, we hold, most unwise to attempt legislation for the segregation of the general body of persons suffering from these slighter, or obscurer, forms of abnormality. But we do think that where their effect is such that the patient is chronically unable to abstain from breaking the law, some special form of non-penal detention, for longer, but not for indefinite periods, should be made a legal alternative to terms of imprisonment. (Howard Journal 1926)

The term 'psychopaths' was adopted to refer to this group. Some prison medical oficers - such as the psychoanalytically-oriented Hamblin Smith - thought the term unsatisfactory and even questioned whether the so-called psychopaths formed a distinct or unified psychological type. But even Hamblin Smith agreed that the psychopaths - whatever one called them - were a recognizable group within the prison and therefore had to be called something.

> There is a large group of cases which have been described under the unsatisfactory title of 'psychopathic personality' as well as under equally objectionable titles. But the nomenclature is comparitively unimportant; for the group is well-recognised, although ill-defined. It is probable that we shall, ultimately, be able to divide these cases into several distinct classes. In my view, some of these cases are simply minor degrees of, what is, in a more advanced form now treated as certifiable insanity. But whether this view is correct or not, it is clear that these cases are inadequately handled under the present system. (Hamblin Smith, in Howard Journal 1926)

What needs to be stressed is that the there was no theoretical advance whatsoever involved in introduction of the term 'psychopath' into practical penal discourse. The term was adopted purely as an administrative category. As Hamblin Smith had stated in an earlier address to the Howard League, the category of psychopaths consisted of a heterogenous group of offenders about whom very little (psychologically) was known.

> . . . Then we have that very mixed group at present classed together

> under the head of psychopathic states, cases of inadequate personality and of sexual perversity of various kinds, a class of which we have at present very little accurate knowledge, and upon whom a great deal of work requires to be done. . .
> (Hamblin Smith 1924)

In fact the term psychopath was used simply to refer to those who had previously been known as moral imbeciles, moral defectives, and as morally insane. Right up until the 1950s these terms were being used virtually as synonyms (see Critchley 1951: 33-50). In 1957, the Royal Commission on the Law relating to Mental Illness Mental Deficiency introduced its discussion of psychopathy by stating that it was going to discuss the term 'psychopath', "which is now commonly used to describe patients whom the 1904-8 Commission called 'moral imbeciles' and 'morally insane'" (Official Pubications 1957: para. 158).

CHAPTER 7

PSYCHOPATHY AND PENAL POLICY

INTRODUCTION

In this chapter I will look at how the term 'psychopathy' has been used in penal discourses since the 1920s. Since there is a multitude of references to psychopathy this will clearly not be an exhaustive, nor even a comprehensive, account; rather I will concentrate upon a few selected issues and themes. I will start by looking at how the phenomenon of psychopathy has been defined in penal discourses. I will suggest that there has been a noticeable change in definitions of psychopathy since the 1920s. While in the 1920s and the 1930s the term was often used quite broadly to refer to any psychological predisposition to crime or delinquency, it gradually came to be used in a more restricted manner, to refer to 'cold', 'emotionless', disordered characters. This trend was in many ways the opposite of that which occurred during the nineteenth century, when the category of moral insanity gradually took on a broader meaning (see chapter 5). I will suggest that it is possible to detect here an attempt by psychiatry to 'withdraw' from its involvement in the management of 'psychopaths'.

An important issue concerning definitions of psychopathy is the interaction between theoretical definitions of psychopathy and the practical uses of the category. Definitions and practical uses are connected in an obvious way; the way psychopathy is defined strongly influences (but by no means determines) how the label is applied in practice. If persistent law-breaking is regarded as a defining feature

of psychopathy, then recidivists are likely to be labelled psychopaths. However, the practical application of the label is only partly determined by theory. Non-theoretical, practical concerns of those involved in penal treatment and administration have also played a considerable role in determining who is diagnosed or classified as a psychopath. I will try to show, for instance, that the category has often been used to exclude difficult cases from treatment programmes or to justify the placement of these difficult cases in special institutions. It is important to realise that, while theoretical definitions influence the practical use of the category, the practical use of the category, in turn, almost certainly influences theoretical definitions of psychopathy. Those involved in research into psychopathy often conduct their research by observing the behaviour, attitudes and 'moral histories' of those whom penal administrators have classified (partly for practical, non-theoretical reasons) as psychopaths. Theoretical definitions of psychopathy are partly based upon such observations. It seems reasonable to suppose that a different set of practical problems could lead to a different type of person being classified as a psychopath and hence to a different definition of psychopathy.[1]

DEFINITIONS OF PSYCHOPATHY

The term psychopathy has not been used in a consistent manner since the 1920s. Rather its use has varied between different users and different periods. In the 1930s, for instance, the term was often interpreted very widely. Psychoanalytic-oriented writers, such as R. D. Gillespie (1930), used the term to include most recidivists, along

with compulsively delinquent adolescents. In his article *The Service of Psychiatry in the Prevention and Treatment of Crime*, Gillespie estimated that psychopathic personalities constituted about 45 per cent of the prison population. The size of this estimate raises the presumption that Gillespie was using the term 'psychopathic personalities' in a broad sense, in much the same way as the category of 'moral imbecility' had been used. Gillespie seems to have included most 'habitual criminals' or recidivists within the category of psychopathy. However, he also used the term even more widely than this. In fact, in his article Gillespie expresses relatively little concern for the plight of adult psychopaths, whom he regarded as beyond successful treatment (ibid: 26). Gillespie's main concern was with those who had shown signs of psychopathic traits, but who had not yet developed into full-blown psychopaths. In such cases, he suggested, the tendency towards psychopathic conduct and attitudes had still not become totally engrained into the character and there was therefore the chance that with treatment it would be posssible to reform such characters and to prevent them from developing into adult psychopaths. Accordingly, Gillespie argued for a change in the law so that those who displayed psychopathic traits could be placed under supervision, before they started to commit offences, in order that they might receive treatment.

> Too often, . . . they [i.e. psychopathic personalities] cannot readily be placed under the necessary supervision till they commit a punishable ofence, when it is already too late for prevention. Yet the potentialities can readily be recognised beforehand, and treatment instituted which might well be preventive of further trouble. (Gillespie 1930: 26)

This raises the question of how Gillespie, and others who shared his views, defined those with 'psychopathic traits'. Since this category included, by definition, many juveniles who had not been convicted of any criminal offence it was not possible to define this category by reference to a propensity to commit offences. In Gillespie's article, no precise criteria are laid down. However, he did present an impression of the type of person who would be considered as a psychopath. This characterization of the psychopath appears to have been based upon Gillespie's observations of psychopaths in prisons (ibid: 26).

> Such persons are essentially unstable, very easily elated and as readily depressed, vain and selfish, often sentimental and childish, or resentful, irritable, grudge-bearing and suspicious. They are easily led, bear responsibility badly, and resort readily to alcohol and to delinquencies such as forging cheques. Their capacities cannot be measured with the appearance of qualitative exactitude that applies to mental deficiency; *but the history is typical and makes diagnosis not difficult.*
> (Gillespie 1930: 26, emphasis added)

What Gillespie appears to have done is to have constructed an 'ideal type' of 'the psychopath' based upon his observations of the habits, characteristics and attitudes of imprisoned psychopaths. Presumably, adolescent delinquents who displayed similar traits might be classified as psychopaths, the degree to which they were regarded as psychopathic being determined by how closely they matched the image of the 'ideal' psychopath. We might surmise, then, that any compulsive delinquent who appeared to be psychologically abnormal, but who didn't fit any other established psychiatric category, would have been regarded as a psychopath by Gillespie. However, an important element in Gillespie's description of 'the psychopath' is his reference to 'history'. In order to tell whether a person is a psychopath, or a

potential psychopath, it is useful, and perhaps necessary, to look at their history. The psychopath has a long history of anti-social attitudes and conduct. This emphasis upon the history of the case as an essential element in the 'diagnosis' of psychopathy appeared in the work of a number of psychiatric writers on psychopathy, such as East (1949) whose ideas I will look at shortly.

Up until the 1960s many writers on psychopathy tended to use the term in a broad sense, similar to the way in which Gillespie had used it. For instance, in 1939 Sir David Henderson, the venerated author of the first British book specifically about psychopathy stated:

> . . . the term psychopathic disorder is the name we apply to those individuals who conform to a certain intellectual standard, sometimes high, sometimes approaching the realm of defect but yet not amounting to it, who throughout their lives, or from a comparatively early age, have exhibited disorders of conduct of an anti-social nature, usually of a recurrent or episodic type, which, in many instances, *have proved difficult to influence by methods of social, penal, and medical care and treatment and for whom we have no adequate provision of a preventive or curative nature.* The inadequacy or deviation or failure to adjust to ordinary social life, is not mere wilfillness or badness which can be threatened or thrashed out of the individual so involved, but constitutes a true illness for which we have no specific explanation.
> (Henderson 1939: 16-17, emphasis added)

I have emphasized an important feature of Henderson's definition of psychopathy, his reference to the failure of existing methods of intervention to influence the psychopath or to even provide adequate provision for the psychopath. On this definition of psychopathy, the psychopath is a person whom existing agencies, whether psychiatric, social or penal, can neither 'cure' nor handle. The psychopath is partly defined by reference to the failure of existing methods of intervention. 'Psychopathy' is therefore, in part, an administrative category. What distinguishes the psychopath from others is not only

his conduct and attitudes, but also the fact that existing institutions have been unable to 'cure' or manage him (or her).

This tendency to define psychopathy partly by reference to the person's institutional record appears time and again in psychiatric descriptions of the psychopath. In the 1940s and early 1950s psychopathic youths were described as

> . . . unruly and depraved children, quite immune to all normal educational and psychological methods. Hence they are generally not influenced favourably during their detention in an approved school. (Frey 1948/9: 229)

For Neustatter (1953: 252) a crucial distinctive feature of psychopaths was that "disciplinary treatment . . . has virtually no effect upon them". Neustatter practically defined psychopaths in terms of their institutional needs, regarding psychopaths as those who were least likely to respond to the proposed 'Hubert-East institutions' (ibid: 255).[2] To move forward to the late 1950s and 1960s, Snell (1959) described psychopaths as "difficult, aggressive, and *unresponsive* prisoners" (emphasis added). Craft (1966a) listed one of the "clinical features" of psychopathy as "an inability to profit by, or use experience, which includes a lack of response to punishment". Taylor (1966) regarded as psychopaths those whom other 'helping' agencies - such as welfare, hospitals, schools, training schemes, prisons, and borstals - have failed to help. West (1968) pointed out that "psychopaths benefit little from the treatment available in ordinary mental hospitals, and they are very destructive of routine". Finally, Whitely (1968) described the psychopath as "dependant upon welfare agencies and accustomed to being taken care of in a hospital or prison".

An important exception to this tendency to use the term psychopathy in a very broad manner is East (1949). It is significant that unlike Gillespie, who was concerned primarily with interventions outside and on the boundaries of the formal penal system, and unlike Henderson, who developed his ideas in a psychiatric context and had little official contact the penal system, East had occupied central positions within the penal system - in particular he was the Medical Director on the Prison Commission in the 1930s - and his views dominated official penal policy for a lengthy period.[3] As Garland (1988) has pointed out, "East was himself a proponent of a psychological approach to crime, but he viewed its scope as being sharply delimited, and consistently warned against the dangers and absurdities of exaggerating its claims." Hence East agreed with the American writers Healy and Branner who, in an American study of 4,000 juvenile delinquents, 'found' only 2.8 per cent with psychopathic personalities, and who went on to argue

> . . . we firmly stand against the diagnosis of psychopathic personality made simply on the basis of repeated misconduct without other signs of psychopathic trends - there are too many other causations of misconduct. (quoted in East 1949: 127)

East also agreed with his colleague, Dr. Hubert, who argue that "the delinquent is rarely psychopathic" (East 1949: 127). East took issue, on the other hand with Kraines, who argued that

> . . . the habitual criminal is a socially sick person who may have a recoverable or incurable illness, the true nature of which can be determined by proper investigation. (quoted in East: 1949: 127)

Against this, East argued

> The habitual criminal . . . is often a person who has deliberately chosen crime as a career, and may show none of the criteria necessary before a diagnosis of psychopathic personality or other abnormality can be made" (East 1949: 127)

East clearly favoured a more restricted interpretation of the term 'psychopathy' than that used by many of his contemporaries. For East, 'psychopathy' was to be used only as a specific diagnostic category, and not as a general category which encompassed all habitual offenders regardless of whether they displayed any other more precise signs of psychopathy. It is important to mention, however, that East did not suggest that diagnosis be made solely upon the basis of a clinical examination. For East, an accurate diagnosis of psychopathy could not be made by relying solely upon clinical examinations; of far more value was a history of the case.

> The Joint Committee on Mental Deficiency . . . reported in 1929 that the diagnosis of mental deficiency may be established without a full history from the data observed by the medical examiner, but it can never be firmly sustained, however much it may be suspected, on the evidence of history alone. This statement loses much of its accuracy when applied to psychopathic personalities in whom a detailed, accurate and complete history may be much more valuable than a personal examimation. Indeed an experienced observer cannot live long in daily contact with a mentally defective person without becoming aware of his abnormality, but one may be on close terms with a psychopathic personality and have no knowledge of his disability. (East 1949: 126)

Despite East's arguments in favour of a more restrictive concept of psychopathy, the tendency to use the term broadly, to include most recidivists and delinquents whose conduct and attitudes suggested psychic abnormality, continued right up to the 1960s. For instance, the *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1954-'57*, whose recommendations led to the inclusion of provision for psychopathy in the *Mental Health Act, 1959*, described psychopaths as persons whose -

> . . . daily behaviour shows a want of social responsibility and of consideration for others, of prudence and foresight and of ability to act in their own best interests . . . persistent anti-social mode of conduct may include inefficiency and lack of interest in any form

> of occupation; pathological lying, swindling, and slandering; alcoholism and drug addiction; sexual offences and violent actions with little motivation and an entire absence of self-restraint . . . Punishment or the threat of punishment influences their behaviour only momentarily and its more lasting effect is to intensify their vindictiveness and anti-social attitude. . .
> (Official Publications 1957: para. 169)

The Commission did not propose a precise definition of psychopathy. This was partly because they thought it "notoriously difficult to describe any medical condition in ordinary language" and "even more difficult to describe or define such conditions in terms suitable to be incorporated in the law" (ibid: para. 166). The Commission preferred to make provision for the care and treatment of psychopaths in general terms, leaving it to doctors to decide who should be included in the category. The Commission also argued that it was wrong in principle to write a detailed definition of psychopathy into the law because advances in medical knowledge might soon make such a definition outdated and inadequate (ibid: para. 33). It was suggested that the law should not to impose a straightjacket upon medical intervention by laying down rigid, legal definitions (which would have to be amended with every advance in medical knowledge), rather the role of the law was to make provision for psychopaths in general terms, and to lay down certain general limits to intervention, leaving the medical profession to precisely define the condition according to the state of medical knowledge at any time. Hence the Commission recommended that new legislation should simply make provision for "psychopathic personalities", the category to include -

> any type of aggressive or inadequate personality which does not render the patient severely subnormal . . . but which is recognised medically as a pathological condition. (ibid: para 1.7)

The government, unhappy about this lack of definition, did write a more restrictive definition of psychopathy into their proposed Mental Health Bill. Psychopathy was to be defined as -

> a persistent disorder of personality (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient and requires or is susceptible to medical treatment.
> (quoted in Walker & McCabe 1973: 219)

As Walker and McCabe point out, this definition was quite precise and restrictive in comparison with that of the Royal Commission:

> It insisted on the importance of *conduct* as evidence of a disorder of personality. Instead of 'aggressive' it said 'abnormally aggressive'. Instead of the vague term 'inadequacy' it referred to 'serious irresponsibility'. . . it insisted that [the disorder] must be persistent. It also stipulated that the disorder must 'require medical treatment' . . . Finally, an important restriction (applying to all the statutory subdivisons of mental disorder) made it clear that nobody could be dealt with under these definitions 'by reason only of promiscuity or other immoral conduct'.
> (Walker & McCabe 1973: 219)

Even so, this definition attracted criticism on the grounds that it was too wide and imprecise. One of the leading critics was Lady Wootton, who had recently written a sharp critique of the concept of psychopathy and of the general tendency towards the over-use of psychiatric concepts in definitions and descriptions of deviance (Wootton 1959; especially chs. 7 & 8). In the House of Lords, Wootton proposed a number of amendments to the definition which, if accepted, would have restricted the legislative definition of psychopathy considerably (see Walker and Mc Cabe 1973: 219). In the event, only one of these amendments was accepted, so the Mental Health Act 1959 defined 'psychopathic disorder' as

> a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the

patient, and requires or is susceptible to medical treatment. (Section 4 (4))

Following the Mental Health Act many psychiatrists continued to use the term psychopathy in a broad sense to include all recidivists. For instance, when H. K. Snell - who had been the director of prison medical services - was invited to contribute to a book on 'psychopathic disorders' he chose to discuss, not those who had been officially designated as psychopaths under the Mental Health Act, but a more general and loosely defined group, 'prisoners with psychopathic traits' (Snell 1966). Snell didn't specify who he considered to belong to this group, but he seems to have included any prisoner whom he regarded as inadequate or aggressive and most recidivists. Snell's article was in fact mostly about recidivism and about how the recidivist could be best treated. This appears to confirm a statement made by Nokes (1976), that during the 1960s habital offenders were routinely referred to as psychopaths by proponents of psychiatric approaches to crime. It should be stressed, however, that this equation of psychopathy and recidivism also took place much earlier, although it was only some psychiatrists who 'routinely' used the term.

During the 1960s, however, the tendency among many psychiatrists was towards a narrower interpretation of 'psychopathy'. Walker & McCabe (1973: ch. 10) show that psychiatrists have tended to interpret the 1959 Mental Health Act definition in a restrictive way. They have tended to exclude many delinquents who, although their behaviour and attitudes suggest psychopathy, are considered to be unlikely to benefit from treatment (see the Mental Health Act's definition of

'psychopathic disorder', quoted above). Since 'untreatability' is a hallmark of the psychopath (as we saw earlier, for many psychiatrists being 'beyond treatment' was a defining feature of psychopathy) this interpretation serves to radically restrict the scope of the category.

It is significant that this restriction of the category should centre around the question of treatability. One of the major problems which social, penal and medical agencies have had to deal with when confronted with 'the psychopath' is what to do with him. Psychopaths are a group for whom very few want to take responsibility (see Ramon 1986). Psychiatric nurses, for instance, have often resisted being 'burdened' with 'psychopaths' (ibid). What seems to have happened is that an ambitious psychiatric profession produced the term in the belief that they could do what others had failed to do, i.e. improve and perhaps even 'cure' the 'psychopath'. However as they begin to discover that they can't improve or cure - nor even manage - the psychopath they have tried to reject them and hence have began to interpret the term in a restrictive way. In fact, the tendency now is to reject the term 'psychopathy' altogether in favour of the less medical-sounding 'personality disorder'. By using this term, which is less medical in its connotations, psychiatrists appear to be trying to define the problem in such as way that penal and social agencies, rather than medical agencies, are seen as the appropriate bodies to handle the problem; the term 'sociopathy (which has been used by some writers in the USA since the 1930s) has been advocated for much the same reason. This suggestion might be supported by the following quotation from Allen (1987), where she distinguishes the two terms.

> In practice the two classifications [i.e. 'psychopathy' and 'personality disorder'] relate to much the same territory of

> personal abnormality at the margins of the psychiatric domain. The classification of psychopathy was developed in an attempt to annexe these abnormalities to psychiatry, and thence to the clinical domain of medical disease. The alternative classification of personality disorder was intended to sever that medical connection, by asserting the continuity of these abnormalities with the broader realm of personal variations" (Allen 1987: 76)

The term personality disorder has not entirely displaced 'psychopathy'. However the tendency now is to use the term psychopathy in a much narrower sense than it was used by many psychiatists between the 1920s and 1960s. The term now tends to be used to refer to emotionless, 'cold' disordered personalities. The 'modern' psychopath is a callous, hedonistic anti-social person who commits crimes - often brutal and horrendous - without feeling any guilt (cf. Jenson 1979). In the modern use of the term it is -

> more precise to speak of amorality than immorality when defining psychopathy, since the term immorality implies a knowledge and an acceptance of morality which is outside the range and understanding of the person exhibiting psychopathy . . . we do face a man called the psychopath who is a lonely wolf, highly impulsive, a victim of his own immediate desires, unable to form lasting bonds of affection with other human beings. (Jensen 1979: 84)

In conclusion, I would suggest that over the last few decades psychiatry has attempted to retreat from its involvement in the management and control of psychopaths, leaving the problem to the penal system. In making this point it should be made clear, however, that throughout the twentieth century the category has sometimes been used not in order to include psychopaths within treatment programmes, but in order to *exclude* them from such programmes. As Prins (1986: 158) points out, the 'label' has often been used "pejoritively and as a defence against involvement". Nevertheless the decision to use the term 'psychopathy' might be interpreted as a sign of a willingness on

the part of some psychiatrists to adopt the problem and to assume responsibility for the management of psychopaths. From the 1920s to the 1960s many psychiatrists appeared to be willing to at least try to 'cure' and manage psychopathic offenders.

By their own admittance, psychiatrists have been unsuccessful in this venture. Psychiatrists have openly admitted that they have no 'cure' for most cases of psychopathy (ibid: 159). They have also made it clear that they have great difficulties in even managing psychopaths, particulary aggressive psychopaths (ibid). In the face of these problems it seems that psychiatrists have been increasingly reluctant to take responsibility for the problem (ibid: 158-9). Psychiatrists, it seems, are now so concerned to pass the problem of psychopathy back to the penal system that that they are undoing the psychiatric label, and redefining the phenomenon in non-psychiatric terms. In this instance at least, it might be more appropriate to think not about the medicalization of deviance, but about its virtual opposite, the de-medicalization (or rather the de-psychiatrization) of crime and social control.

CONCLUSION

Throughout this thesis I have tried to describe the way medical concepts have been used in penal discourse since (approximately) the mid-nineteenth century. In doing so I have tried to show that this medical terminology has often been misunderstood, particularly by many of those who have criticised what they see as an increasing tendency towards the medicalization of deviance and social control. As I result of this misunderstanding, I would suggest that the changes which have taken place in the methods and rationale of social control and in analyses of delinquency, in Britain since the nineteenth century, have also been misunderstood. Much of my argument has been that medical concepts have been used in penal discourses in complex and varying ways and that this complexity has not often been realized or analyzed, particularly by the critics of 'medicalization'. Throughout the thesis I have tried to unfold this complexity and I have tried to specify the ways in which particular concepts, such as 'treatment' 'inebriety' and 'psychopathy', have been used in penal discourse, by different writers and at different times. To try to summarize these arguments at this stage might therefore be counter-productive, since it would undermine the point that these concepts have not been employed in a singular way or with a singular meaning. By way of conclusion, then, I will confine myself to a few general remarks about some of the implications of this study for our undertanding of 'medical' and psychiatric interventions in the domain of crime, delinquency and social control.

In chapter one of this thesis I outlined an influential critique - which has been developed over the last few decades by some sociologists and legal theorists - of the therapeutic approach to social control. There are of course dangers in oversimplifying that critique, but bearing this in mind it seems fair to say that this critique appears to be based upon an image of the therapeutic approach to social control as an activity geared towards altering the attitudes and behaviour of deviants with the objective of inducing deviants to conform to social norms, this alteration being achieved through the use of medical-scientific techniques which are in turn based upon an analysis of the delinquent as a mad, sick, determined being. The analyses of the use of medical concepts in penal discourse which I have undertaken in this thesis suggests that this image of the therapeutic approach to social control is inadequate and, in many respects, inaccurate. I would suggest that the therapeutic approach to social control is more diverse and quite different from the image portrayed by its critics.

First, if we look at the objectives of the therapeutic approach to social control we find that in trying to alter the habits and attitudes of delinquents it has been concerned to do *more* than simply induce conformity to the law and social norms. If we take, as just one example, the objectives of the rehabilitation hostels advocated - and in few instances established - for habitual drunkards in the 1960s and 1970s we find that their aim was not only to ensure the habitual drunkard's conformity to the law. Nor was the objective simply to turn the habitual drunkard into a sober person. These objectives were pursued, but other objectives were

given even greater priority. One of the main objectives was to improve the habitual drunkard's *social competence*. Of course, the capacity to abide by the law and to stay sober were considered to be important aspects of social competence, but other capacities, such as the capacity to hold down a steady job, to establish lasting relationships with other people, and to settle into a domestic life-style were considered to be even more important. A central objective appears to have been to socially integrate individuals who had been excluded from social associations through a number of circumstances, mostly psychological, but also social and economic (cf. Cotterrell 1984: 33).

These objectives - and the other objectives of the therapeutic approach to social control which I have identified throughout this thesis - should of course be scrutinized in terms of their desirability and feasibility. All I am suggesting here is that before this critical task can be undertaken we need to obtain a better understanding of what the objectives of the therapeutic approach to social control have actually been. In this thesis I have tried to contribute to such an understanding by looking at how those involved in the therapeutic approach to social control have employed 'medical' categories and concepts such as 'treatment'.

My next point concerns the methods used to further these objectives, What critics of medicalization appear to object to is the use of 'scientific' techniques, such as pharmacological treatments, surgery and aversion therapy (e.g. Kittrie 1971; Box 1980). These techniques are objected to on the grounds that they bring about changes in the criminal's attitudes and habits, whether the criminal desires such change or not (see

chapter one). Whether these techniques are actually capable of producing the effects imputed to them is itself an issue which deserves to be examined in more depth. What I have suggested in this thesis, however, is that when those who deal with offenders talk about 'treatment' they are more often than not referring to something quite different than pharmacological treatment, surgery, etc. Often the term 'treatment' is used to refer to *social therapies*. The central idea in social therapy is to put the offender in an institutional environment in which he will learn the social skills necessary to live in society in a personally satisfying way and without becoming a nuisance and a burden to others. The 'techniques' recommended for achieving this have been outlined in detail throughout the thesis and I will not summarize them here. However, an important point about most techniques of social therapy is that they appear to be incapable of bringing about changes in the offender unless the offender *voluntarily* makes an effort to acquire 'self-control' (see e.g. chapter three). It is inaccurate to characterize such methods as 'enforced therapy' (cf. Kittrie 1971) since they generally rely upon the co-operation of their subjects and indeed are incapable of producing change in those who refuse to co-operate. Once again it is necessary to scrutinize these methods, however the first task is to understand exactly what has been advocated in the name of 'treatment'.

To turn, finally, to the changes in the way delinquency has been analyzed. As we have seen, the critics of medicalization object to the suggestion that delinquents are sick, mad, determined beings. One of the points which I have tried to make in this thesis is that although

proponents of the therapeutic approach to crime have often hinted, rhetorically, that the delinquent is slightly mad, the actual analysis of delinquency is often more subtle and complex. Yet again, it is necessary to scrutinize these analyses and to not only ask whether they are accurate but to also ask what are their ideological and political effects. The first task, however, is to describe these analyses correctly.

NOTES

Chapter 1 - Medical Concepts and Penal Policy

1. It should be pointed out, however, that although there has been a remarkable lowering of mortality rates and improvement in health since the early nineteenth century, this has been the result, not so much of medical interventions, but of changes in habits, better nutrition and public health measures (Hirst and Woolley 1982: ch.4). These changes were "effected largely by non-medical personnel and did not depend as such on modern theories of disease causation" (ibid: 100; cf. McNeill 1979: ch.6). Nevertheless, as Hirst and Woolley point out, there has been a remarkable advance in the preventative and therapeutic capacity of medical knowledge and practice since the nineteenth century (ibid: 100).

2. See, for example, Alexander Peddie's theory of the causes of 'dipsomania' (which will be discussed in chapter two) and Havelock Ellis's account of 'moral imbecility' (chapter five).

3. On this and the following points see Garland (1988), Foucault (1977a) and Nye (1984: ch.4).

4. In what follows I will consider punishment from the point of view of its use as a form of social control. It should not be presumed, however, that punishment is solely, or even primarily, advocated and used for the purpose of social control. Punishment serves a number of functions - most notably, retribution - of which social control is only one, albeit an extremely important one.

5. For analyses of the operational principles of deterrent punishment see Foucault (1977b: pt.2, ch. 1) and Pasquino (1980: 18-22). For more traditional, philosophical accounts of deterrence see Honderich (1976: ch.3) and Bean (1981: 29-44).

6. Hence advocates of deterrent punishment reached a position similar to that which 'retributivists' reached, although from a very different starting point. In the retributive theory, the principle of proportionality is advocated form the point of view of equity or just deserts - the commission of a crime is regarded as "creating an unjust situation which had to be rectified by the imposition of a penalty roughly equivalent to the pain or suffering caused by the offence" (Rodman 1968: 197).

7. See Jones and Williamson (1979) for a discussion of the relationship between elementary education and moral training in the second half of the nineteenth century.

8. In constructing the following ideal type of the therapeutic approach to social control, I have tried to reproduce the image of the therapeutic approach which is suggested by the critique of medicalization (see pp. 1-2). However, since I am concerned in this thesis with the inadequacy of the conceptual structure which I have called the medicalization thesis, rather than simply with the

inadequacies of specific accounts, I have tried to make a 'best case' for the medicalization thesis.

9. In fact 'liberalism' depended largely upon the effective operation of informal social controls - the family, the market, etc. Welfare states tend to resort to an increasingly formalized range of social controls to complement and support these informal mechanisms.

10. It should be mentioned at this stage, however, that many of the criticisms of 'the medical model' are directed solely at physicalist or biolological theories of delinquency. As I will argue throughout the thesis, these criticisms are particularly wide of the mark.

11. We might also note here the objection lodged by the American Friends Service Committee (1981), which argued that the indeterminate sentence is "systematically discriminatory because those coming from worse backgrounds are deemed to require longer periods of treatment than those from more acceptable backgrounds" (paraphrased in Bean 1981: 69).

12. A topical example would be refusal, on political grounds, to register for the community charge/poll tax.

13. Box's argument here has a close affinity to the claims of anti-psychiatry. For critical discussions of anti-psychiatry see Pearson (1975: ch.2), Sedgwick (1982) and Hirst and Woolley (1982: ch. 10).

14. The contradictions of this argument can be seen, in fact, if we consider the issue of abortion in places where it is illegal. On the one hand abortion is regarded as a rational choice, and having an abortion despite its being illegal is seen as a political action, a refusal to be bound by wrong laws. As Greenwood and Young (1980: 158-9) would have it, abortion is an innocuous activity which is transformed into a social problem merely by the irrational reaction of authority. On the other hand, abortion is regarded as a social problem caused by the economic hardship engendered by capitalism (ibid).

Chapter 2 - The Inebriates Problem

1. The Habitual Drunkards 1879; The Inebriates Act 1888; The Inebriates Act 1898.

2. MacLeod quotes Lord Salisbury, the Conservative Prime Minister in 1895, who was one of the chief exponents of the liberal view: "Here you give power over the liberty of men that you have never given before. You allow a single judge, without appeal, without a jury on an occasion obviously vague, obviously incapable of being reduced to a definite statement - you allow him to deprive a man of his liberty for two years, practically to confine him to prison. . . . My Lords, you are meddling with edged tools" (Lord Salisbury, quoted in MacLeod (1967: 235).

3. The eugenics movement will be discussed later in the thesis, in the chapters on moral imbecility and psychopathy. For more detailed discussions of eugenics see Garland (1985: ch.5) and Rose (1985: ch.3).

4. On the Temperance Movement see Harrison (1971).

5. Unless stated otherwise, material from official publications will be referenced,
(i) according to the paragragh of the report (e.g. para. 2);
(ii) according to the number of the recommendation (e.g. rec'n. 5); or
(iii) where the reference is to the minutes of evidence of the inquiry, according to the question number (e.g. q. 533).

6. The term "punitive treatment" was used by Peddie in his evidence to the committee (q. 954).

7. On the developing concern with recidivism in this period see Radzinowicz and Hood (1986: ch. 8) and Nye (1984: chs. 2-4).

8. A leading example of such classifications is in Booth's 'Life and Labour of the People of London', in which a number of clases were identified, including:
(a) the lowest class of occasional labourers, loafers and semi-criminals;
(b) casual earnings - the very poor;
(c) intermittent earnings - the poor;
(d) small regular earnings - the poor;
(e) regular standard earnings - above the line of poverty;
(f) higher class labour.
(see Williams 1981: ch.7).

9. It is interesting in this context to note the answer which one witness gave when asked how long it might take to cure an habitual drunkard:

> ". . . it depends . . . entirely upon the constitution of the mind; I have known some people, some of those whom I have given as having only been a month with us, who have felt so degraded, and their feelings so lacerated from having been put away from their families and locked up there, that a month has effected a cure. In other cases we found that twelve months did not effect it".
> (Official Publications 1872: q. 2335)

10. These procedures would have effected the position of those who voluntarily entered retreats since, we can recall, once they had entered voluntarily they could then be compulsorily detained.

11. The question of finance often turned upon the nature of the proposed institutions. If, as was widely presumed, the proposed reformatories were to be basically punitive in nature then, it was argued, responsibility for their construction and maintenance should lie with the state rather than with the local authorities, since the punishment of delinquents was solely the state's concern: "The detention of inebriate offenders in reformatories is in part only for their reformation. In part it is a penal measure, and it seems to us improper that punishment should be administered by Local Authorities" (Official Publications 1908: para. 95)

12. Between the 1879 Act - which was an experimental statute designed to have effect for ten years - and the Inebriates Act of 1898, there was another statute - the Inebriates Act 1888. The 1888 act was practically identical, in its provisions, to the earlier statute which it replaced. There was, however,a change in title. This change was due

to the fact that it was felt that the term 'habitual drunkard' was opprobrious; persons who might willingly declare themselves inebriates, would be unwilling to label themselves as habitual drunkards (see Official Publications 1908: para. 16, q. 125). The Departmental Committee on the Inebriates' Acts of 1908 correctly predicted, however, that "... common use and association will probably, in time, render the word 'inebriate' similarly opprobrious" (ibid: para. 16). They thereby identified a recurring problem with attempts to 'medicalize' deviance: i.e. the medical terms which are introduced in order to find a more neutral, scientific term for discussing deviance gradually take on more and more moral overtones, so that eventually, a new term has to be coined, which in turn suffers the same fate. Hence terms inebriate' and 'dipsomaniac' were originally intended as scientific terms, but later became terms of derision; and much the same could be said about the term 'alcoholic', which was used to replace the then opprobrious term, inebriate.

13. "The matter was brought up by Lord Herschell in 1892 in connexion with the wider question of habitual criminals" (Official Publications 1893/4: app. VI, p. 93).

14. cf. the title of a Howard Association publication: '*The Essential Element of Time, for Reformatory or Restorative Success, especially in Reference to Habitual Offenders, Drunkards, and Tramps*' (1897).

15. Because of pro-active policing by the National Society for the Prevention of Cruelty to Children (NSPCC), these provisions eventually provided an important path by which inebriates were sent to reformatories. By 1908 3,000 persons had been committed to inebriate reformatories. Approximately 2,600 of these were multiple drunkenness offenders, while 400 were offenders who were also inebriates. Of these 400, 319 were sent for cruelty to children, "owing to the energetic action of the NSPCC".

16. It should be pointed out here that 'voluntary' admissions to inebriate retreats were often, in practice, far from voluntary: "in many - possibly one might say without substantial exaggeration in most - cases the application for admission is not a voluntary one. It is the result of strong pressure brought to bear on the patient by his friends, and backed by threats to deprive him of supplies unless he yields to it" (Renton and Yellowlees 1896: 89).

17. See Allen (1987) for a discussion of gender imbalance in psychiatric disposals in modern criminal justice.

Chapter 3 - Reforming the Inebriate

1. For a discussion of these values, and of the role they played in Victorian society, see Gray (1977); cf. Thompson (1981).

2. For accounts of moral management see Castel (1983); Digby (1985); Foucault (1971: ch.9); Hirst and Woolley (1982: ch.9); Rose (1985: ch.1); Rothman (1971: ch.6); & Skultans (1975).

3. My concern here to point out why certain elements of Goffman's approach to the study of institutions (in which psychiatric discouse

is a functioning constituent) cannot be applied uncritically to the study of inebriate reformatories. It is not possible here to discuss many central and important aspects of Goffman's account, such as his re-working of the private/public distinction, or the connections he draws between mental hospitals and other 'total institutions'. For more comprehensive accounts and criticisms of Goffman's work see Hirst and Woolley (1982: 183-194) and Sedgwick (1982: ch.2).

4. It is, of course, possible that the psychiatric discourse which I have described is not the same as that which operated within the American institution researched by Goffman. The main point, however, is that Goffman doesn't analyse the psychiatric discourse which operated within the institution.

5. cf. Garland (1985: 3): the study of penal practices "involves something other than a phenomenological description of the sanctioning practices, policy formulation and day-to-day decision-making which take place in modern penal institutions. It requires an exploration of the framework of assumptions, logics and objectives which supports these routine operations and allows them to exist as such".

6. This point is also made by Sedgwick who criticises Goffman's "*methodological localism*" (the term is intended to highlight certain affinities with *methodological individualism* - 1982: 63-5).

> "His method consists of a precocious sensitivity towards those elements of social living which involves the face-to-face adjacency of persons. On all other aspects of the social process, that is to say, on any institution or happening that receives its meaning from outside this immediately shared space among individuals within shouting distance of one another, he is virtually silent . . . the pursuit of the local and the narrowly interpersonal will not provide us with enough grit even to digest the logic of the small scale setting or encounter. The categories we bring to bear in perceiving and judging the actions of a present other are not themselves drawn, in the first place, from our exposure to face-to face situations; thus, the concept of 'illness' . . . while applied and specified within particular encounters between . . . doctor and patient, does not derive its principle meaning or force from such contemporary goings-on, but from an entire history which includes the development of scientific rationality, the evolution of medical institutions . . . The interpersonal has, in short, a chronological or more exactly historical aspect which Goffman overlooks."
> (Sedgwick 1982: 63-4)

7. This term is taken from Donnelly's account of the asylum building programme in the early nineteenth century (Donnelly (1983).

8. Foucault refers to Sellin (1944) for an exhaustive study of this institution.

9. The Philadelphia model is also discussed by Rothman (1971).

10. cf. Richards' discussion of the work of prison psychologists in which he argues that: "...we cannot understand prison psychology solely as an exercise in legitimation, as an ideological suppport for the repressive apparatus of prison, providing a scientised rationale and justification

for policies and decisions made for reasons quite external to the activities of pychologists" (Richards 1977: 21).

11. On the links between anti-psychiatry and more 'popular' cultural criticism, see Pearson (1975).

12. cf. the quotations from Bentham on pages 15-16 of chapter one.

13. The inebriate was often said to be suffering from *moral insanity* (e.g. Symonds 1869). One of the features of moral insanity was that it was the *will* as opposed to the *intellect*, which was said to be diseased. This extremely important notion will be returned to in more detail in my study of the categories of moral insanity, moral imbecility and psychopathy.

14. One of the problems involved in the attempt to provide commited inebriates with profitable employment was the opposition from 'ordinary business' and 'free labour'. To get around this problem it was suggested that "some greater attempt might be made to produce goods now manufactured out of England, and to compete with foreign rather than English free labour" (Official Publications 1908: pp. 26 & 167). In the case of women, however - who, we can recall, constituted the majority of reformatory inmates - there was less of a problem. The domestic work which was considered appropriate for women presented no threat to free labour. Domestic work could be useful, and even profitable - e.g. laundry work - without being seen as a threat by ordinary business and free labour.

15. However, Foucault goes on to state: "In the asylum, work is deprived of any productive value; it is imposed only as a moral rule . . . " This may have been the case in the York Retreat described by Foucault, but it was certainly not the case in the inebriate reformatories where the emphasis was firmly upon *productive* labour, as opposed to labour *per se*.

16. We might also note here that the temperance movement, whose approach to the problem of drunkenness was often criticized by the inebriety reformers, had, as early as the 1830s, argued that one of the chief causes of intemperance was the fact the pubs were more comfortable - had a more domestic atmosphere - than working class houses, which were often more places of work than homes as such (see Harrison 1971).

17. See the section in chapter two on neglect of domestic duties. We might also look at this concern with buildings which would be 'light and airy' in the context of the public health movement of the nineteenth century, in which such buildings were seen as necessary in order to prevent the contagion which ocurred in the dark, confined spaces of the dwellings of the poor. Just as light and airy spaces could prevent physical contagion, so they were seen as useful in preventing 'moral contagion' (cf. Pearson 1975: ch. 6).

18. In 1927, long after the principle of strict determinate sentencing had lost favour among penal policy officials, the idea of the indeterminate sentencing was still regarded with suspicion, even by reformers who had helped to undermine the idea of the strictly determinate sentence. In a Howard Journal (which was a major outlet for penal reformist ideas) review of J. L. Gillin's *Criminology and*

Penology', it was stated: "On one point we differ from Prof. Gillin entirely. He advocates the absolutely indeterminate sentence, without any maximum (p. 711), and this is a power we refuse to give to any official body; the more, as there seems some danger at the hand, led by fanatics, appealing to science to give support to their prejudices and disguised instincts. Thus, any unpopular individual, or even any helpless minority, might be put away as abnormal, or dangerous to society. Anti-vaccinators, vegetarians, sunbathers, and especially any group of sex-life reformers, might easily be classed as 'degenerates' and shut up where they would cease from troubling. The English people will never allow the building of a Bastille." (Howard Journal 1927 - the review was probably written by George Ives).

19. Some witnesses at the 1872 inquiry wanted the maximum to be two years (Official Publications 1872: 'discussion of amendments')] and later three year sentences were advocated. The three year sentence eventually became law.

20. The following statements are typical: "I think there is a popular impression abroad . . . that there is some sort of specific treatment for drunkenness; some radical cure. No such thing within my knowledge exists" (Official Publications 1872: q. 2717); I do not think medical treatment is of the faintest use. All these drink cures, I think, are pure frauds" (Official Publications 1908: q. 736).

Chapter 4 - Rehabilitating the Vagrant Alcoholic

1. The inebriate reformatories fell into disuse during World War 1. In part 1 of appendix 1 I have constructed a brief account of the habitual drunkards problem during the interim period (roughly 1914 - 1960). Tether and Robinson (1986) have summarised the major landmarks in the modern campaign to establish a treatment system for habitual drunkards; the relevant excerpt is reproduced in part 2 of the appendix.

2. Consider the following:
> "The proposed structure of this comprehensive treatment system is the interlocking of *medical* and social work conceptions, since the alcoholic... is simultaneously diseased and socially disaffiliated. The advocates of treatment suggest that it is fundamentally necessary for *psychiatry* and social work not to operate in isolation from each other if they are to fulfill their aims"
> (Archard 1979: ch. 1, emphasis added).

3. These terms are taken from Rose (1986: 70-82). The term 'social therapies' refers to the techniques of resocialisation, developed by the therapeutic community movement, but also utilized - in various forms - in other institutions, such as prisons and - as we shall see - in hostels for recovering habitual drunkards. These will be discussed in more detail later. 'Behaviour therapy' refers to the systematic use of sanctions and rewards to readjust malformed personalities. Behaviour therapy is not confined to harsh techniques - such as aversion therapy - but consists of a wide range of techniques of closing the gap between behaviour produced and behaviour desired; techniques which are employed in a wide range of social practices. The

term 'therapies of normality' is difficult to define in a short space. It refers to the myriad of psychological techniques which have blossomed since the 1960s - particularly in the USA - and which are designed to change us from what we are, into what we desire to be.

4. On the relationship betwen social work and other professions - and between social work and other knowledges - see Clarke et al (1980).

5. The term 'the disease concept of alcoholism' is popular in the literature on this subject, probably because this was the title of E, M. Jellinek's influential book, published in 1960.

6. The working party's report referred only to England and Wales; see Moody (1979) for a review of literature on drunken offenders in Scotland.

7. In the following I have drawn upon the analysis of Clarke et al (1980).

8. These were 'discovered' during research into the background of selected groups of habitual drunkards, e.g. people appearing in court on drunkenness charges, prisoners with a record of drunkenness convictions, alcoholic patrons at a soup kitchen (see Official Publications 1971: ch.5; Cook et al 1969: part A). The researchers compiled biographical details of habitual drunkards and - although they denied his existence - constructed an image of the typical habitual drunkard. This was in order to provide a portrayal of the 'habitual drunken offender' as he is, but also to suggest what type of person becomes such an offender and why: "by what processes and interaction of causes his life takes that path" (Official Publications 1971: paras. 5.6-.11). References to these characteristics are scattered throughout a variety of texts, reports and articles. Here, in order to avoid being cumbersome, I will confine myself to just one or two references for each point.

9. It should be recalled that these characterisations were constructed at a time of relatively full employment.

10. See Light (1986) for a more complete account of the origins and development of the term 'skid row'.

11. Following the logic of utilitarian theory (see chapter 1), it could be argued that punishment would not deter the alcohol addict from drinking. Since the alcoholics's drinking is not controlled by his will, he cannot stop drinking even though he might be able to rationally calculate that drinking is not in his ultimate best interest: ". . . if these men are alcohol addicts they are unlikely to be influenced by a fine of ten shillings, or a day's imprisonment"(Gath 1969).

12. I will discuss this in more detail shortly. It can be noted that this criticism corresponded to the nineteenth century inebriety reformers' concern for *controls from within* rather than exernal control (see ch.3); this concern was derived, in turn, from the principles of moral treatment.

13. This criticism was also directed against 'staff-directed' hostels for homeless alcoholics; the paternalism of these hostels was seen as an obstacle to therapy (see Official Publications 1971: ch. 10)

14. The employment of medically or psychiatrically qualified staff was not sought. The hostels would ideally be staffed by trained social workers, while secondment from the prison service and from the probation and after-care service was also recommended. Staff would be trained to develop:
"(i) An acute awareness of the skid row culture and the vagrant way of life in large cities;
(ii) A close-knowledge of hostels, the regimes that are possible in them, the interaction within them, their limitations;
(iii) A general knowledge of casework and groupwork principles, implying an understanding of personality growth and behaviour patterns; &
(iv) An understanding of the social and medical aspects of alcoholism."

15. Rathcoole house was established as an experimental hostel in May 1966. For accounts of its regime see Pollak (1969) and Cook (1971) and (1975: 15-28). A second hostel, 'Lynette avenue', was opened in 1968 (Cook 1969 & 1971). Hostels for habitual drunkards are discussed more generally in Official Publications (1971: chs, 10 & 11). On therapeutic communities see Rose (1986: 70-77), which contains references to the most important primary sources. See also, Unsworth (1987: 263 ff).

16. Cook (1975: 23) cites one resident of Rathcoole House as remarking: "I came here for sobriety not all this responsibility."

17. The reasons for the adoption of this rule are explained by Cook (1971) & (1975: 17-20).

18. These terms are taken from Gordon (1986).

19. This was not so much out of a committment to a general environmentalist theory; rather in those cases where habitual drunkenness appeared to be the product of organic disorder the person was excluded from treatment.

20. This is a matter of degree rather than a hard and fast distinction. As we saw earlier, the inebriate reformatory programme also involved proposals for the surveillance and control of inebriates outside of the reformatory. The main emphasis in the nineteenth century was, however, on the estabishment of institutions for the confinement of the inebriate. By the 1960s/1970s there had been a substantial shift in emphasis away from the institution.

21. This experiment, which took place in Edinburgh, is described by Hamilton et al (1978: see ch.7 in particular). The experiment was more successful when transferred to a psychiatric hospital, where habitual drunkards were under the care of psychiatric nurses. Hamilton et al's account is interesting in its discussion of the problems of trying to deal with habitual drunkards in a setting which operated, to a large extent, in accordance with a 'medical model'.

Chapter 5 - Moral Insanity, Moral Imbecility and Penal Policy

1. While I will concentrate on the use of these terms in penal discourses it is necessary to bear in mind that since the penal and the social cannot be conceived of as separate and exclusive realms - they are interpenetrating and interdependent (Garland 1985: viii) - we should not regard penal and social discourses as separate and exclusive types of discourse. In fact, this thesis should lend support to the contention that the penal and the social are intermeshed.

2. On the philosophichal conception of the moral sense, see Raphael (1973). For a critique of this concept, see Burt (1925: 32 on).

3. See Rose (1985: introduction) for an account of how this transformation is represented in conventional histories of psychology.

4. See Burt 1925: 34; Donnelly 1983: 137; Walker and McCabe 1973.

5. See, for instance, the case of *J. K.* in Prichard (1837), reproduced in Skultans (1975: 183-4).

6. These more general writings included works of anthropology and ethnology. These were related to a more general project which I will outline. For a short account of Prichard's more general work, see Leigh (1961). The following is based upon Leigh's account and upon the excerpts from Prichard's general work which Leigh reproduces.

7. Hence Prichard, from his starting point of religious doctrine, reached a position similar - if not quite equivalent - to that of empiricist philosophers such as Condillac and his psychiatric disciples, Itard and Pinel. Prichard's belief in the fixed nature in man, given by God, appeared on the face of it to be directly opposed to the empiricist belief that all knowledge, ideas and attributes are the product of experience. Nevertheless, his eventual conclusion was similar: that mental characteristics were the product of the individual's environment. The 'Englishman', cut off from a civilised environment would become a savage, and vice versa. Hence Itard's renowned attempt to turn Victor, the *enfant sauvage* into a normally socialised being (in this case to turn him into a Frenchman) by creating, around him, suitable environmental conditions. (see Jones 1972: 182; Hirst & Woolley 1982: 43-58; Rose 1985: ch.1; & Malson 1972, which contains a translation of Itard's *The Wild Boy of Aveyron*).

8. Relevant excerpts form Maudsley are reproduced in Skultans (1975); on Tredgold's view on this point see Burt (1925: 37).

9. On the differences between environmentalist theories of evolution, which saw the environment as having a *direct* influence upon physical structure, and the more complex theory of Darwin (and later Darwinists), see Hirst and Woolley (1982: ch. 1).

10. For those committed to classifying all theories pertaining to human conduct as either voluntarist or determinist this can only appear as a contradiction between moral condemnation and scientific determinism. For some, the very term 'moral insanity' contains such a contradiction. Some nineteenth century doctors criticised the concept because it incorporated ethical connotations into a disease description (see Smith 1981: 114). This criticism was reiterated by

Critchley in 1951: "For many reasons the term is a bad one, not the least being the use of the adjective 'moral' to describe a set of psychiatric phenomena. It is to borrow the terminology of one discipline to describe another; an intrusion of theology into medicine" (Critchley 1951: 38).

11. See Donnelly (1983: 71-3). A standard text on these issues is Walker (1965). See also Foucault [ed.] (1975) and Smith (1981).

12. See the trial of Neville Heath, reproduced in Critchley (1951), for a classic confrontation between 'moral insanity' and 'the M'Naghten Rules'.

13. On these issues cf. Castel (1975).

14. The story of moral insanity intersects here with that of habitual drunkards. As we saw earlier it was in the same short period - from the mid 1860s to the early 1870s - that the problem of inebriates emerged. As I argued in chapter two, the problem of inebriates was seen as an aspect - and often the most important aspect - of the problem of the criminal class. For many, the two groups - 'inebriates' and 'criminals' - overlapped almost exactly. Symonds (1869), for instance, introduced an article on the inebriates problem with a long discussion of moral insanity, arguing that "'moral insanity' is close to 'uncontrollable drunkenness' in the issues it throws up".

15. Maudsley also stated: "It may be said that this description is simply the description of a very wicked person, and that to accept it as a description of insanity would be to confound all distinction between vice and crime and madness" (Maudsley (1874).

16. Importantly though, while mental defectives were considered incurable, it was thought that most of them could be improved - i.e. "their lives could be made less burdensome, and their usefulness increased" - (Jones 1972: ch.8; cf. Rose 1985: ch. 1).

17. See in particular Haynes (1864/5), who presents fifteen illustrative cases. One of these cases is reproduced in an appendix 2.

18. The biography of moral insanity could also be used as a moral fable, to illustrate how factors such as being spoilt as a child, or masturbation, could lead to moral insanity (and eventually to intellectual insanity) in later years (see Haynes 1864/5, case 1).

19. The following features are more or less present in a large number of cases illustrative of moral imbecility. For examples, apart from those in Haynes (1864/5) which I have already mentioned, see those in Sullivan (1920).

20. See in particular, the case in appendix 2; cf. the case of Pierre Rivière (Foucault (ed.) (1975).

21. Ellis later rejected atavism as an explanation of criminality (Ellis 1910: xxiii), but adhered to the general arguments of criminal anthropology.

22. This is not to say that there was no opposition to the power of psychiatry in this period. To the contrary, in the second half of the nineteenth century there was a major movement towards subjecting psychiatric powers to the rule of law (see Jones 1972, especially ch.

7; & Unsworth 1987: ch.3). However the nature of this campaign should be clarified. It seems clear that major strategy of legalist campaigners in this area was not so much to protect lunatics from confinement, but to protect *sane persons* from wrongful confinement as lunatics. Jones (1972) characterises the legalist approach as "piling safeguard on safeguard *to protect the sane against illegal detention* . . ." (ibid: 153, emphasis added).

23. Confinement of the insane had been conventionally justified as being necessary to ensure the insane person's own security, to protect their families, and to maintain public order (e.g. Prichard 1837: 205).

24. It is necessary to stress that 'the criminal class' was in practice - if not in theory - defined according to social and behavioural criteria. Membership of the criminal class was not based upon the possession of certain mental characteristics, rather it was based upon one's social status, and in particular upon one's criminal record. The class consisted of vagabonds, drunkards, mendicants and, most importantly, recidivists.

25. On eugenics, and its implications with regard to penal and social policy, see Garland (1985: 142-52). On Ellis's views on eugenics in general, see his 1922 essay, *The Individual and the Race*, republished in Ellis (1939).

26. This proposal long proceeded that of East and Hubert in 1939 for the establishment of a special institution for the reform or containment of, and research on, abnormal and unusual types of criminal. East and Hubert's proposal eventually led to the construction, in the early 1960s, of Grendon Underwood psychiatric prison (see Gunn et al 1978: 19ff).

Chapter 6 - The Introduction of 'Psychopathy' into Penal Discourse

1. From reading the Butler Committee's report one gets the impression that Pinel and Gröhmann were simply describing entities which already existed: e.g. "Pinel *described* 'manie sans délire'"; ". . . in 1818 in Germany "moral diseases of the mind" were *described* . . ." (Official Publications 1975: para. 5.4, emphasis added).

2. The Butler Committee, for instance, stated that they would give an account of the origin and development of the *concept* (as distinct from the term) of psychopathic disorder. But such an account is not possible unless it has a fairly clear idea of what the concept - whose origin is being described - is. But the Butler committee do not even present a working definition of the concept. Such a definition would be particularly required in tracing the history of psychopathy since, as the Butler Committee state, the term 'psychopathic disorder' has been (and still is) subject to a wide variety of usages (see Official Publications 1975: para. 5.2).

3. Hence one work on psychopathy, by D. Curran & P. Mallinson, was entitled "I can't define an elephant but I know one when I see one" (see Ramon 1986: 216). On the other hand H. Cason compiled a list of two hundred and two ways in which psychiatrists had defined psychopathy (see Clyne 1973: 147). Dr. P.D. Scott, one of the leading writers and practitioners in the field of psychopathy during the 1950s and 1960s, could offer nothing more precise than a definition of a

psychopath as "one whose persistently anti-social or a-social behaviour cannot be primarily attributed to mental abnormality or psychosis, and stimulates society to treat him" (quoted in Clyne 1973).

4. See Rose (1985: introduction) for a discussion of this way of thinking about psychology.

5. See Watson (1988: ch.4) for a discussion; (cf. Black 1966).

6. As the criminologist D.J. West put the matter (albeit somewhat ingenuously): "Men who would be inevitably diagnosed as psychopaths by some middle-class psychiatrists, on account of their impulsively hedonistic conduct and seemingly callous neglect of social reponsibilities, may be looked upon as very ordinary by their own fraternity. According to the predilictions of the observer, the same man may be regarded as a heroic freedom fighter, a criminal terrorist, or an aggressive psychopath" (West 1974: 2).

7. Conrad and Schneider (1980). More generally, see chapter one of this thesis.

8. In the 1870s psychiatry was only beginning to emerge as a specialty; it is therefore not possible to draw a sharp distinction between doctors of physical medicine and psychiatrists, at this stage. When psychiatry did become established as a specialty, its importance within the prison medical service gradually increased so that by the late 1940s it was considered the most important part of the prison medical service (see Gunn et al 1978: ch.1).

9. The term feeble-minded had been used as early as 1876 (Jones 1972: 184) but not in the specific sense described here. For a detailed acount of the 'discovery' of the feeble-minded, see Rose (1985: ch.4).

10. This, of course, should be understood as a shift in emphasis, not as a total rupture in schooling practice. Schools had previously been concerned with the transmission of literacy and numeracy, and they continued to be regarded as places of instruction and training in moral and domestic habits. The argument is that the priority attached to each of these functions was inverted in the second half of the nineteenth century.

11. For an account of the separate system see Rothman (1971: ch.4). On the 'birth of the prison' in general see Rothman (ibid) Ignatieff (1978) and Foucault (1977b). On the late Victorian penal system (1865-'95) see Garland (1985: 6-18).

12. On this point cf. Garland (1988); & Miller (1986: 39).

13. Designations of feeble-mindedness were often supported by the flimsiest of psychological evidence. For instance, in 1903-4, the medical officer at Pentonville Prison declared that forty per cent of Pentonville's inmates were feeble-minded (Jones 1972: 192). This opinion was evidenced by the results of literacy tests (ibid). As Jones points out, the literacy test was a particularly "blunt tool" at a time when compulsory education had been in operation for so short a time (ibid). What she fails to make clear is that this 'blunt tool' was supplemented by other behavioural and social criteria. Being sent to Pentonville was in itself enough to raise a suspicion of feeble-

mindedness; and as we have just seen, prisoners were more likely than others to attract a diagnosis of feeble-mindedness because they were institutional inmates. The literacy test might have been used as evidence of feeble-mindedness, but it was not the sole criterion for designations of feeble-mindedness.

14. And there were also leading theorists who understood the distinction but didn't regard it as being of great importance. Tredgold, for instance, - who was one of the leading theorists of mental deficiency - was of the opinion that cases of moral defect without intellectual defect were rare (Official Publications 1908b: qq. 7363 & 7422-3).

15. The commission claimed: "The mental condition of these persons, and neither their poverty nor their crime, is the real ground of their claim to help from the State" (cited in Jones 1972: 194).

16. This style of argument is discussed by Garland (1985b: 22-3): ". . . criminology operated precisely by producing 'special cases' or categories of individual who should not be subject to the normal procedures of legal accountability because of their irresponsible or abnormal characters. However these 'special cases', once established, had a tendency to extend their domain - and that of criminology - and we can cite many instances where a special case is established only to have its special features erased in the name of its subsequent extension" (ibid: 22).

17. See Official Publications (1908b), @ vol. 38 of the parliamentary papers.

18. Much of the argument of chapter three, which dealt with treatment in the inebriate reformatory, would therefore apply here also.

19. Burt writes: ". . . in theoretical discussions, there is *now* an *increasing* tendency to adopt to the second (interpretation)" (Burt 1944: 31, emphasis added). It should be noted that these lines were written in 1925. This confirms my earlier suggestion that the distinction between the feeble-minded and moral imbeciles was not well established, except in the highest of psychiatric theory, before the 1913 Act.

20. See also Gunn et al (1978: 14-5) & Gibbens (1966), who both suggest that the designation 'moral imbecile' was rarely used in practice. For a detailed account of these issues see Watson (1988: chs. 4-5).

It might be noticed that the 1957 Commission used the term 'moral defective' which replaced the term 'moral imbecile' in an amending statute, the Mental Deficiency Act, 1927.

21. We can include here a third position which, strictly speaking, should be treated as distinct. In this third position - which was in its infancy at this stage but would later become of great importance - the distinction between the intellectual and the moral faculties was practically refused altogether in favour of a unitary conception of the mental. In this unitary concept of 'mind' or 'personality', the 'intellectual' and the 'moral' were conceived as interdependent. Defective morality therefore implied defective intelligence; and correspondingly, intelligence was conceived as consisting of ability

to adapt to society as well as possession of cognitive skills. This was the position of Burt (1925/1944, see in particular chs. 1-2), and later formed the basis of Henderson's (1939) influential work *Psychopathic States*. The distinctive feature of this position was its focus upon social maladjustment as the key element of mental disorder.

22. From the time of its first publication in 1921 the Howard Journal has been a major forum for discussion among high grade penal officials and other penal-welfare professionals. The vast majority of contributors - especially before the 1970s - were practitioners, working either within the prison system or in experimental penal institutions at the boundary of the penal system. This is reflected in the content of the journal in which theorising about crime, delinquency and punishment is linked to professional concerns about the classification of offenders and the improvement (reform) of the penal system. The Journal's content was, and to a very large extent continues to be, within the tradition of practice-oriented criminology described by Garland (1988).

23. It was reported that:

> During the last four years 985 mentally defective persons (787 men and 198 women) have been dealt with under sections 8 and 9 of the Mental Deficiency Act, 1913 and (a) sent to Mental Defective Institutions by the Courts instead of being sentenced to imprisonment, or (b) certified as mentally defective under section 9 and removed to institutions whilst undergoing sentence, or (c) sent to a 'place of safety' pending the presentation of a petition on their discharge from prison. (Howard Journal 1926)

Chapter 7 - Psychopathy and Penal Policy

1. See appendix three for a discussion of how the phenomenon of psychopathy has been explained.

2. On the Hubert-East institution see footnote 26 of chapter five.

3. See the account of East's career in 'Society and the Criminal', which is a collection of some of East's essays; see also Garland 1988).

APPENDIX 1

PART 1: The Habitual Drunkards Problem, 1914 - 1959

The inebriate reformatory system fell into disuse during the First World War (Radzinowicz and Hood 1986: 313-5; Gunn et al 1978: 13; East 1949: ch. 3). The most usual explanation for this is that the system collapsed because of financial and administrative difficulties (Gunn et al: ibid). Radzinowicz and Hood (ibid) propose a deeper explanation: the penalisation of inebriety offended public sentiments. Another explanation is that of the Home Office Working Party report *Habitual Drunken Offenders* (Official Publications 1971), which argued:

> The Acts were conceived and administered at a time when little was known about the therapeutic approach to alcoholism, and this must have contributed both to the deficiencies of the reformatories themselves and to the doubts felt by the courts about their effectiveness. (quoted in Radzinowicz and Hood 1986: 314).

After the war, official concern with the problem of habitual drunkards was relatively low-key. What concern there was came largely from within the context of prison administration and was restricted, for the most part, to the problem of managing inebriates who were sent to prison (see e.g. Morton 1929). Very little interest was shown in the vast majority of drunken offenders, who were fined; while those who might be considered as inebriates even though they had never committed a drunkenness offence, lay beyond the scope of official concern altogether.

Most of those who addressed the problem of inebriates in this period continued to stress the need for an alternative form of disposal to imprisonment. This was the policy, for instance, recommended by J. Hall Morton, who was a governor and medical officer of H.M. Prison, Holloway. Morton advocated a threefold classification of inebriate prisoners: young prisoners, senile alcoholics, and adult alcoholics. For young prisoners he suggested -

> probation with a condition of residence, i.e. placed in a suitable home for a period of not less than six months and in persistent or recurring cases . . . twelve months . . . I believe that this treatment of the young alcoholic would have a most beneficial effect, and that in a short time these girls would give up alcohol. (Morton 1929: 310).

Senile alcoholics were to be committed "to the Union for at least a year" (ibid). Adult alcoholics were to be sent "to some sort of colony

in the country, where they would be employed on the land, self-supporting". Those that wanted treatment for alcoholism, and who were prepared to co-operate, would receive it and after a certain period would be allowed out on trial (ibid).

There were those, however, who were willing to concede that the imprisonment of habitual drunkards - while not the most desirable of disposals - could achieve some good. In their history of prison psychiatry, Gunn and his collaborators point out that while nineteenth century prison administrators were preoccupied with the problem of how to remove 'quasi-criminal' groups from prison, in the post World War I period this concern gave way to an increasing commitment to a policy of 'treatment' *within* prison (Gunn et al 1978: ch. 1). This change is reflected in discussions of the problem of habitual drunken offenders. The nineteenth century inebriety reformers had believed, unequivocally, that prison was not the place for the inebriates. By the second third of the twentieth century, however, a more modified view was being voiced. Those who addressed the problem now tended to agree that while prison was inappropriate for the habitual drunken offender, there were nevertheless certain benefits to be obtained from imprisonment. On being sent to prison, the habitual drunkard underwent enforced abstinence from alcohol and would receive the care and attention of medical staff; he might even receive some psychiatric treatment. So while it was still maintained that alternatives to imprisonment were necessary, it was also conceded that, until these alternatives were available, 'penal treatment' should still take place. This more modified view was put by G. Scott, in 1949. While arguing that imprisonment of habitual drunkards was undesirable, he conceded that "prolonged sentences might be valuable because of the enforced abstinence", and that "it is only in prison that they have any chance of rehabilitation, mental, moral and physical" (Scott 1949: 175-6).

Much later the Home Office Working Party tempered their criticism of the imprisonment of habitual drunkards, in a similar manner:

> As a minimum, a period of custodial care allows for drying out under medical supervision, accompanied by attention to the physical deterioration which is frequently present . . . Medical officers, particularly in large remand prisons, are experienced in dealing

with problems and complications of this kind. With offenders who are serving short sentences attention to these physical ills is all there is time to attempt. But we would stress that the importance of this attention should not be underestimated. The effect of these periodic stays in prison on the health of problem drinkers is significant" (Official Publications 1971: para. 7.13)

PART 2: Major Landmarks in the Habitual Drunkards Campaign of the 1960s and 1970s

(excerpt from Tether P. and Robinson D.: *Preventing Alcohol Problems*)

"Fresh attempts in the UK to find alternatives to punishment for the habitual drunken offender gained momentum during the 1960s and 1970s. The aims of these efforts were to keep the habitual public drunk out of prison and to establish alternative facilities for treating and helping them. Changing penalties for drunkenness, a Home Office report, and changes in departmental responsibility for the habitual drunken offender all reflect these aims. The major landmarks were:

* Section 91(1) of the Criminal Justice Act 1967 which provided for the abolition of the short period of imprisonment which could be imposed for the offence of being drunk and disorderly. At the same time, the fine was increased to £50. However, the Act stated that imprisonment for this offence could not be abolished until sufficient, suitable accomodation became available for the care and treatment of persons being convicted of being drunk and disorderly
* The 1971 Home Office report of the Working Party on Habitual Drunken
Offenders which recommended the establishment of 'detoxification centres' to which drunks could be taken for care, assesment, and advice and from where, if necessary, further help and assistance could be arranged. The working party defined 'habitual' as more than three convictions in a year and calculated that about 16 per cent of drunken offenders fell into this category. The report also recommended the development of other local facilities such as hostels and advice centres.
* Section 34 of the Criminal Justice Act 1972 which allows the police
to take public drunks to a place approved by the Secretary of State as a 'treatment centre for alcoholics'.
* In 1973 responsibility for habitual drunken offenders' rehabilitation was vested in the DHSS although, of course, the police retain responsibility for enforcing the law. DHSS Circular 21/73 urged local government and health authorities to collaborate in the provision of hostels and other services for the habitual drunken offender. 'Pump-priming' funds were made available for a limited period to encourage this development.
* The Criminal Law Act 1977 activated the provisions of the Criminal Justice Act of 1967 regarding the abolition of imprisonment for drunk and disorderly offenders. Commencement Order (No. 4) came into force on 1 February 1978. It was argued that 'suitable accomodation' had become available. Circular 21/73 had led to over seventy hostels being established. In addition, two detoxification centres had been

set up under section 34 of the Criminal Justice Act of 1972 and a third centre was planned.

Despite these initiatives, most public drunks who come to the attention of the police sober up in police cells, or in A and E departments. The range of facilities envisaged by circular 21/73 either failed to materialize or, where they did, often failed to survive the expiry of pump-priming funding.

The attempt to keep drunkenness offenders out of prison has also largely failed. Although the Criminal Law Act of 1977 abolished imprisonment for being 'drunk and disorderly' it also increased the fines for drunkenness offences. In 1977, 2,270 people went to prison for non-payment of fines. This figure had risen to 2,698 by 1982. In the following year the figure fell to 2,467 but the trend is once again upward.
(Tether and Robinson 1986: 285-6)

The legal position in Scotland differs somewhat (see Hamilton et al 1978; Moody 1979; McLaughlin 1985).

APPENDIX 2

A CASE ILLUSTRATIVE OF MORAL IMBECILITY

(from Haynes 1864/5)

"Case 15.-P.H-, aet. 16. In this case there is a long hereditary predisposition; his father and paternal grandmother died insane. From a very early age he evidenced a great propensity to steal, and used to take things of little or no use to him - these things he used to secrete. He was sent to a succession of schools, but was obliged to leave each of them after a while; one in consequence of his being known or strongly suspected to have appropriated books; another, because the master of the school expressed his conviction that the young man was certain to end his life on the gallows; and on different other occasions no reason was assigned, but it was simply requested he might be removed. While at these schools he was always thought to have some deficiency about him, and to be mentally unlike his school-fellows, who recognised the fact. When visiting friends he was in the occasional habit of helping himself to books, especially sensation novels and railway guides, which constituted his most acceptable mental pabulum. His intellect is of high order; his correct memory of dates, places, and times, is extraordinary; he has travelled a great deal in Great Britain (having a passion for railroads), and knows the lines running in each town he has visited (and their name is legion), and the times at which the trains arrive at, and depart from, the stations, to and from other stations; like Mr. Wyndham, he was fond of driving trains himself, or of being in the guard's van.

Shortly prior to his admission he had disappeared from his mother's residence in Scotland, after having, in her name, drawn £200 from a bank; the next thing heard of him was by a letter sent to his mother from London stating he had invested the £200 in railway shares along with £500 he had received from a nobleman for some great service he had rendered him, the nature of which he would explain on his return. This statement was entirely without foundation. During his sojourn in London (where he remained for some time) he devised a plot which, for refined ingenuity and diabolical cunning, would have made an excellent foundation for one of those morbid productions, unhappily now so common, termed - and only too appropriately - *sensation* novels. The plan he proposed to carry into effect was to obtain the assasination of an uncle and cousin, in order that he might, as next heir, inherit a large estate; he offered £12,000 for the murderers. The police heard of the plot, an investigation was made and was terminated by the young man being placed in the Royal Edinburgh Asylum; the adoption of this course appears to have satisfied the uncle who had reasonably become very much alarmed, and the police.

I have previously mentioned proofs that his memory is extremely clear and retentive; to a certain extent he is clever. His judgment of other persons, and of the motives which influence them, is, in some respects, very true and rapid, in others obviously and remarkably deficient. He soon finds out whether a man is conceited, absurd, or a fool, but does not seem to recognise the fact that any of his fellow-patients are insane; he does not attach any psychological or pathological importance to what they do, but speaks of them as "vapid

asses", "fools". He does not consider himself a patient, or to think that he is looked upon as mentally affected. He seems incapable of judging whether a man has any emotions or passions - whether he is generous or selfish, religious or blasphemous, highminded or depraved. For those who are excited and quarrelsome, or miserable and misanthropic he has no compassion or sympathy; according to him they are equally "fools" or "vapid asses".

When questioned about his proceedings in London and asked whether he was cognisant he had done wrong, he replied he supposed he had; but he could not be made to appreciate that it was a subject of any import, to express any regret or to be ashamed of himself. If spoken to about his plot he does not attempt any defence of his intentions, or to palliate them, but speaks of them as a matter of course, and altogether shows a deplorable want of feeling as to what is right and what is wrong; he seems, in fact, quite incapable of judging at all between the two. The only apparent check upon his committing actions which are wrong is, his dread of being found out - not because they are wrong.

He has always been very gentle and affectionate in his disposition, especially to his mother, whom he seems to love in the same way as a daughter might be expected to do. There is very little manliness about him; he seldom appears to be speaking honestly and in a straightforward manner; while speaking he often looks at one in a stealthy, cunning, cat-like manner; with his eyelids drooping; for a long time (until indeed laughed out of it) he would not play cricket, and when he plays he is well padded, and avoids every ball at all likely to hit him; when skating he always pushed a chair before him; if trying to go at all fast, if without the chair, he was very uncomfortable, and went with great caution, manifesting the greatest dread of falling; the approach of a wasp or bee causes him to shrink and to shriek with a short cry of agonised terror; in any games he attempts he displays an absolute want of courage. He is very fond of whist; although told, over and over again that hints are not allowed, and that tricks must not be looked at after turning them over, he is constantly winking or nodding at or hinting to his partner, and frequently turns over the tricks to see what cards have been played; when detected cheating, and spoken to about it, he says, "No, its not a good plan. I see it doesn't do." He seems to lack the boldness of dancing anything more than a quadrille, while the idea of waltzing never seems to enter his imagination. At meals he does not think of the possibility of others liking what he relishes until he has had enough; for instance, if there were a few strawberries on the table, he would eat them all unless something else happened to tempt his appetite. So long as things are done or got for him, he never considers the trouble which may be entailed on others. When any of his numerous attempts at deceit are discovered, and he is spoken to about them, he laughs, and seems to think them good jokes. He said he is intimately aquainted with a noble duke and other members of the peerage, whereas the contrary is known to be the fact. It is stated that soon after he came here he offered a minister a living in England if he would become an Episcopalian. He also said that in consequence of his coming here the meals were very much improved.

For some months he has been receiving instruction in mathematics and kindred subjects, and has made great progress, showing a more than

average intellect, and this notwithstanding that he is extremely apathetic about it. If he had a problem to solve, and finds it at all difficult, he will not exert himself to overcome it, but says it is a "beastly one," or a "bore," or "ridiculous," and tries by all the means in his power to avoid it. He is very irregular in his attendance, making all kinds of frivolous pretences and excuses; one day he says he could not attend in consequence of a severe attack of tic (which he never has), another, that his mother is coming to see him, &c. While at work the least thing suffices to arrest his attention; if any one passes he jumps up to see who it is, where he comes from, and whither he goes. He is extremely inquisitive.

He seems totally destitute of the moral sense, or any capability of distinguishing right from wrong, and never once was known to characterise any act, although calculated to excite the utmost indignation in a well-regulated mind, as a thing which was wrong, but simply as "a bad plan, or "foolish," and that only because it had been found out" (Haynes 1864/5: 546-8).

APPENDIX 3

THE SEARCH FOR THE 'ROOTS' OF PSYCHOPATHY

Since the 1920s psychiatrists working on the problem of 'moral imbecility' and 'psychopathy' have speculated as to the causes of the condition. There have been a number of competing explanations. In this appendix I will suggest that this contest cannot be characterized as being simply between an organicist approach and a psychological approach (cf. Ramon 1986), rather there has been a more complex, multi-faceted contest, involving many distinct, although often intersecting, approaches to the explanation of psychopathy. It is also necessary to keep in mind, when considering these explanations, that those who produced them often had very different ideas about what it was that was being explained (cf. chapter 7).

Physicalist approaches

Physicalist approaches are based upon the hypothesis that psychopathic conduct is, in some sense, the product of an underlying physical abnormality. Such explanations have been made with regard to all the definitions of psychopathy that I have outlined. It is important, however, to distinguish two quite different suggestions which those who have adopted a physicalist approach have made. It is sometimes implied that psychopathic conduct is caused *directly* by some underlying physical abnormality, such as brain disorder or a genetic-based propensity towards aggressive, anti-social conduct. Much of the research from the 1930s and 1940s on psychopathy as a product of brain disorder appears to be based upon such a presumption (see McCord &

McCord 1964: 61-70). However, 'physicalists' have also put forward a more limited and subtle thesis, viz. that psychopaths suffer from some constitutional weakness which leaves them unable to learn how to behave and to relate to others in a normal way. Hence Frey (1948/9), an outspoken proponent of biologial explanations of psychopathy and a forthright critic of environmentalist explanations, suggests that biological abnormality leads to psychopathy *indirectly* by making the person "immune to all normal educational and psychological methods" (Frey (1948/9). This is extremely important because it implies while psychopaths cannot be *cured* (in the absence of any effective technique of altering their biological make-up) they could be *improved* if new educational and psychological techniques, capable of reaching those with a constitutional predisposition to psychopathy, could be invented. Educational and psychological methods may not be able to cure the psychopath, but they might still be capable of morally educating the psychopath to some degree. This explanation of psychopathy, although quite different from environmentalist explanations, is not too far removed from environmentalism in terms of the remedies it proposes.

In what follows I will try to show that many of those engaged in the pursuit of physicalist explanations, especially in more recent years, have often made quite limited claims for their theories. Although in the 1920s doctors were probably over-confident of their ability to explain psychopathy in physicalist terms, there has been a gradual tendency since then, among those involved in research on psychopathy, *not* to make sweeping claim about psychopathy being explicable in solely physicalist terms.'

Physicalist approaches to the explanation of psychopathy received a boost in the 1920s as a result of a number of outbreaks of *encephalitis lethargica*, more popularly known as 'sleepy sickness' (see Walker and McCabe 1973: 10 & 211). Sleepy sickness was a virus disorder which often caused brain damage. In children, an after-effect of the disease was a propensity to restless, aggressive and destructive behaviour (ibid: 10).[2] Some doctors argued that the behaviour of children following sleepy sickness was similar to that of moral imbeciles and psychopaths. In a Howard Journal article titled 'Moral Degeneration Following Sleepy Sickness' Dr. G. A Auden was quoted as arguing "that moral changes, especially in the direction of thieving and lying, frequently occur in children after an attack of sleepy sickness" (Howard Jounal 1926). Biologically-oriented psychiatrists used observations such as this to suggest that psychopathy might be explained by organic malfunctionings within the brain (see McCord & McCord 1964: 27). If brain damage could lead to 'psychopathic conduct' in post-encephalitis children, then perhaps, it was suggested, brain disorder might be responsible for psychopathic conduct in general (ibid). This led some researchers into psychopathy to study the brains of psychopaths.

Research on the brains of psychopaths continued over the next few decades (see Craft 1960/1; 239-240; Craft 1968). After the Second World War, the study of the psychopath's brain was furthered by the use of the electroencephalograph (EEG) (Fabisch 1966). The EEG, which records the electrical activity of ganglion cells or neurones of the brain, has been used in research on psychopaths at places such as the Northgate Clinic, an observation unit for the assessment of

psychopathic disorder among juvenile delinquents (O'Connell 1968) and at Grendon Psychiatric Prison (Butler 1975). However the rationale behind EEG testing seems to be somewhat different from that which informed much of the earlier research on the psychopath's brain. Instead of arguing that brain abnormality *causes* aggressive conduct etc., it is simply argued that there may be some correlation between aggressiveness etc. and abnormal EEG patterns. If such a correlation could be found it might help to explain psychopathy but it would not in itself imply a direct causal relation. The rationale behind EEG testing has been explained by Fabisch:

> It might be expected that such facets of psychopathic personality as physical and emotional immaturity, emotional instability, rapid swings of mood, and proneness to apparently unpredictable and explosive reactions might be accompanied by abnormal EEG patterns. (Fabisch 1966: 85)

This research has indicated that a large number of those labelled as psychopaths do have abnormal EEG readings (Fabisch 1966; Gibbens 1968). However those involved in such research have often warned against reading too much into these findings. It has been pointed out that EEG measurement is a complex technique which produces a mass of information and that to say that somebody's EEG pattern is abnormal involves making a crude judgement based upon the most conspicuous features (ibid). Another problem which has been identified is the looseness and generality of definitions of psychopathy, a factor which has led researchers to be circumspect about any statements concerning correlations between 'psychopathic conduct' and abnormal EEG patterns. Hence Fabisch states:

> Unfortunately, since a simple and unequivocal definition of psychopathy is not available and since simple and unequivocal diagnostic EEG patterns do not exist, any attempt at defining psychopathic states with the help of an EEG is bound to be somewhat

limited. (Fabisch 1966: 85)

Another attempt to explain psychopathy which we can classify as physicalist is the *'genetic'* approach. Those involved in this research have tried to discover whether psychopathic personalities differ in their genetic make-up from normal personalities. A recurring problem with genetic approaches is that it is difficult to distinguish between personality traits which are due to genes and those which are due to early environment (Craft 1960/1). Hence nineteenth century hereditarianist arguments, which were often supported by showing that delinquency 'ran in the family', have been dismissed by most twentieth century students of the role which genes play in determining personality (see Craft 1966b). An alternative approach, which has been developed since the 1930s, is the twin study. By studying the personalities of twins separated at birth, researchers have tried to determine how much of personality is determined by genes and how much by environment (Craft 1960/1). Many of those involved in such research have, however, made it clear that the task is an enormously difficult one and that there is insufficient evidence to sustain a simple genetic theory of psychopathy (ibid; Craft 1966b).

Clinical-psychological approaches

In the 1920s attempts were made to explain the causes of psychopathy in purely psychological terms. I will refer to these attempts as clinical-psychological approaches, in order to distinguish them from social-psychological approaches which I will discuss later. The clinical-psychological approach aimed to find some stable psychic characteristic which correlated with psychopathy. To this end, ethical

or temperament tests were devised. In order to appreciate the significance of these tests it should be pointed out that around about this time there was a marked increase in the popularity of intelligence testing. In the 1920s the idea that intellectual ability (and hence intellectual defect) could be precisely measured with intelligence tests became widely accepted among psychologists (cf. Rose 1985: ch.5). However, attempts to devise equivalent 'ethical' or 'temperament' tests - or tests capable of measuring 'moral sense' - met with little success (see Watson 1988: ch.4). Nobody could devise a test which was capable of measuring 'emotional attitude' or of discriminating between those whose emotional attitude was normal and those in whom it was abnormal. Ethical tests were devised, but those whose conduct was indicative of psychopathy often passed them. Hence, in 1926 one prison medical officer stated:

> I am at a loss to discover any method of localizing the moral sense. The condition has from the point of view of examination, no clinical entity and the signs and symptoms of such a mental state cannot be demonstrated apart from social behaviour. The cases that, on the evidence of past conduct should perhaps be regarded as moral imbeciles actually give on examination no ground for the assumption. They can pass all the ethical tests to which we can submit them, and it is only on the conduct side that they fail. The whole position is one of emotional attitude, and too often this is not revealed to the public gaze. (Rees Thomas, quoted in Watson 1988)

Forty years later psychologists were still unsuccessful in their attempts to devise tests which would enable them to "disentangle the psychopath" from other psychiatric groups (see Black 1966).

A note on the contribution of psychoanalysis

Psychoanalytic explanations of the phenomenon known as 'psychopathic behaviour' are extremely complex and it is not possible for me to outline them in the space available here.[3] Instead I will confine

myself to a few general remarks about the impact which psychoanalysis has had upon the understanding of psychopathy. First, although some psychoanalysts (especially Glover 1960, section 4) have defended the concept of psychopathy, and have tried to explain the phenomenon in psychoanalytic terms, orthodox psychoanalysis has tended not to use the concept, preferring to use its own psychoanalytic categories to explain the conduct and attitudes which others refer to as psychopathy. There is no simple intersection between psychoanalytic categories and the category of psychopathy. Many psychoanalytic categories - such as 'instinct-ridden character' (ibid: 135-6) bear a striking resemblance to 'psychopathy', but there is no simple fit between the two categories. Nevertheless psychoanalysis contributed to explanations of psychopathy in a more general way. Some of those involved in the study and treatment of psychopathy 'borrowed' certain concepts from psychoanalysis in order to explain the phenomenon. However, in the process, the borrowed concepts were generally reformulated and simplified. A central example concerns Freud's idea that there was no adult neurosis without an infantile neurosis (ibid: 132-3). This formula was often extended to character disorders so that, in the hands of Glover, it became "no adult 'pathological crime' without 'infantile pathological delinquency'" (ibid). Psychoanalysis therefore *helped* to focus attention upon the links between childhood troubles and adult psychopathy. However, as we shall see, many of those who studied this link tended to study it in a somewhat non-psychoanalytic manner. Instead of focussing, for instance, upon the development of libido, there was a tendency to focus exclusively upon the child's early *'social'* environment

It is important not to overstate the contribution of psychoanalysis to explanations of psychopathy. As I shall try to show, psychoanalytic-oriented explanations of psychopathy often owed more to older ideas about the interaction of the environment and character (such as those surveyed in earlier chapters) than to orthodox psychoanalysis. Psychoanalysis added a new gloss to these ideas, and probably enriched them to a certain extent, but the ideas were not themsleves derived directly or solely from psychoanalysis.

Social-psychological explanations

In the early 1920s, shortly before the epidemics of sleepy sickness occurred, a series of brutal murders were committed by youths (Howard Journal 1922). Many of these murders were practically inexplicable; there were no obvious motives and the youths involved were not suffering from any recognised form of mental illness. For the author of an article in the Howard Journal, these murders were the product of "obscure obliquities, moral and mental, of which science tells us little" (ibid). Nevertheless, this author put forward a tentative explanation: the murderers were the victims of involuntary childhood neglect (perhaps combined with a constitutional weakness of mind) which occured as a result of the Great War. The murders could not therefore be blamed solely on the youths who committed them, rather the whole of society was implicated in the crimes:

> The only thing we do know is that in each case we have a weakling who has been subjected to stresses greater than he could withstand . . . These youths, with all their darkness of mind, are the final product of a world at war; their crimes are our crimes. for they are the result of involuntary neglect during the formative years of their childhood; and we slay them for our sins."
> (Howard Journal 1922: 79)

So shortly before the phenomenon of disruptive and aggressive behaviour following bouts of sleepy sickness was interpreted as evidence for a physicalist explanation of psychopathy, this series of brutal murders was interpreted as a sign that the child's early environment could be a major cause of later immoral and brutal behaviour. The two approaches were not as radically opposed as they might appear to be. The 'environmentalist' approach was not necessarily opposed to the suggestion that 'psychopaths' differed in their constitutional structure from non-psychopaths. To the contrary, a weak constitution might explain why some victims of child neglect turned into brutal murderers, while others led a normal life. But a weak constitution on its own could not explain psychopathic conduct. To use more modern terminology, a weak constitution might '*predispose*' one to psychopathy, but the child's defective early environment was the main cause.

In the 1930s an explanation of this type was suggested, with specific reference to psychopathy, by R. D. Gillespie (1930). Gillespie employs a number of psychoanalytic ideas. He argues, for instance, that many psychopaths behave as they do because they want to be punished, an argument which Freud had made some years earlier with regard to criminals (Freud 1916). Gillespie also sounds psychoanalytic when he suggests that since the child is the father of the man, the childhood delinquent is the father of the adult criminal (Gillespie 1930: 23). This meant that the roots of psychopathy were to be found by looking at the delinquent's upbringing and parental management, rather than by examining the psychopath's physical body. For Gillespie *most* pscyhopathic personalities, like most mental illnesses, were the

product of environment: "Symptoms which were once thought to lie in the physical body are now recognised as stemming from the patient's past environment" (ibid: 23). Gillespie approaches the child's upbringing in a more 'social' way than orthodox psychoanalysis. For Gillespie the child's environment consists of the social relations immediately surrounding it, social relations which could be altered if only attempts were made to do so. On the other hand, Gillespie did not tend to use the term environment in a 'macro-social' way. Although he sometimes used the term to refer to social conditions in general he usually employed the term to refer the child's more immediate environment, i.e. its mother and others - such as schools - directly responsible for the upbringing of the child (ibid: 26). Gillespie's main argument was that faulty training and upbringing were the main cause of psychopathy. So the mother who spoilt or neglected her child constituted a bad environment and was therefore in danger of turning her child into a psychopath (ibid).

Before examining this idea further it is important to note that Gillespie did not believe that all cases of psychopathy could be explained in this way. Gillespie argued that a *majority* of cases were environmentally caused; he accepted that some cases of psychopathy were the result of inherited or congenital causes (ibid: 26). This 'concession' to the physicalists actually plays an important part of Gillespie's argument. Gillespie's argument was that since most aspects of psychopathic personality were the product of faulty upbringing, they *could* be altered through corrective training:

> . . . the majority of psychopathic personalities acquire important parts of their unstable disposition as the consequence of faulty training and environment. To that extent they can be re-educated and

reformed. (Gillespie 1930: 26)

By implication, those few whose unstable disposition was mostly the product of congenital abnormality were beyond reform. This supplies Gillespie with a simple method of distinguishing between predominantly environmental and predominantly heredity cases. All cases should be subjected to corrective training; if this was successful then the condition was clearly the product of "mother's spoiling", if 'treatment' was unsuccessful then it was likely that the condition was physically-based (ibid: 26). This argument is remarkable in that it inverts the conventional relationship between diagnosis and treatment; diagnosis was to depend upon the outcome of treatment, rather than vice versa. We might also note that this meant that psychopaths were to be classified as 'constitutional psychopaths' or 'social psychopaths' by reference to the failure of penal and socialization practices.

The process by which faulty upbringing could create psychopathic personalities was addressed by many writers on psychopathy during the 1930s and 1940s. However, before looking at some of these it is important to note that many of them did not completely rule out the possibility that physical or constitutional factors could play an important role in producing the psychopath. Just as 'physicalist' explanations were not *radically* opposed to environmentalist explanations, so environmentalism did not wholly exclude physicalist accounts. The difference between these two types of explanation was often one of emphasis, rather than a sharp opposition.

J. R. Rees (1933) argued that many of the features of criminality or psychopathy (Rees' makes little or no distinction between these terms)

could be seen in the young children. However, young children soon became socialized; they developed more social attitudes, emotions and conduct, and therefore found it relatively easy to adjust to society. But some children never developed in this way - even though they may have developed in every other way, including intellectually - and hence remained, emotionally and behaviourally, at the level of the child. Either 'abnormalities in temperamental make-up' and/or a difficullt environment could be the cause of this failure to develop normal emotions and values. Either the psychopath's temperamental make-up leaves him unreceptive to socializing influences or the socializing influences are themselves absent or defective.

> The comparison of the baby with the criminal, which has been made, is illuminating and contains a great deal of truth. The infant in its earliest days is completely ego-centric, self-loving and indulgent. Its main objective is the attainment of the things which give it pleasure, and it has not arrived at any social values or sense of its place in the community. Granted a so-called normal environment, the infant begins to grow up and in so doing becomes increasingly socialised as time goes on. Abnormalities in temperamental make-up and difficulties in environment will certainly render this process of social adjustment more difficult . . .
> (Rees 1933: 30)[4]

A similar analysis of psychopathy is presented by Henderson who regarded psychopaths as -

> . . . people who psychobiologically have remained at an immature, individualistic, egocentric level, who are determined to get their own way irrespective of the cost, who fail to grow up to any sense of reality. . . . Their emotional development and their judgement and forethought have not kept pace with their ideational component. . . . Their higher inhibitory control mechanisms are in abeyance and they are dominated by their emotional instincts.
> (D. K. Henderson, quoted in East 1949: 128-9)

The references to 'immaturity' and 'failure to grow up' imply that psychopathy results from a failure in the development of the child, a theme already explored by Rees. However, in reading Henderson's

argument it is also useful to recall another idea about 'development' which was once seen as relevant to the analysis of delinquency: the development of civilized man from primitive man (see ch. 5). For Henderson's 'higher inhibitory control mechanisms' we might substitute 'moral sense'. Those persons in whom the moral sense remains uncultivated are in a state similar to that of the savage - "they are dominated entirely by their emotional *instincts*" (empahasis added). The instincts which lead us to act aggressively and individualistically are *controlled* in the civilized man who has learnt to control his aggression and to curtail his pursuit of selfish desires where the cost of this pursuit to the *community* is too great. The psychopath is a person who is constitutionally unable to learn self-control.

The theme (which we might denote the child-adult/savage-civilized theme) has appeared in numerous accounts of psychopathy and was not confined to any one usage of the concept or to any one explanatory school. For instance, East (1949), drawing upon an article on 'character' by A. F. Shand,[5] argued that there were three stages in character development: (i) the *instinctive* level, represented in the animal; (ii) the *emotional* level, represented in the child; and (iii) the *sentiment* level, represented in the adult. East argued that the psychopath was between stages two and three; his character development had either ceased at this stage, or else he had *regressed* (ibid: 130). Craft (1962: 49 & 1966b) makes explicit reference to this theme by comparing the psychopath to the wild boy of Aveyron. Whitely (1968) described the psychopath as emotionally immature and infantile and as "primitive, egocentric and id-like".

The link which had been drawn between problems in child development and later delinquency led a number of researchers to focus attention upon the problem of delinquency among children who were evacuated during the second world war. (Rendell 1943; Wills 1945). This research was concerned with the effect which early separation from parents had upon the child's future behaviour. After the war Dr. John Bowlby (1945/6) undertook his research into the "childhood origins of recidivism", once again focussing upon the affects of early separation from parents and unsettled upbringing. Moving forward to the 1950s, we find Scott, in his paper 'The Psychopath' (1958), drawing upon research on the development of the child's personality in order to explain the role played by various factors in causing psychopathy. While not denying the importance of 'constitutional' or 'physiological' factors, Scott argued that no understanding of psychopathy was possible until personality development was understood (Scott 1958: 7). For Scott, the main shaper of personality was the *early relationship* between the child and those who cared for it. He argued, therefore, that although environmental factors were an important contributory factor in many cases of psychopathy, a bad environment was seldom the direct cause of psychopathy. Environmental factors were most likely to lead to trouble when 'acting in the presence of' a "*predisposition*" to psychopathy (ibid). A predisposition to psychopathy - or 'latent delinquency' - was determined by "long continued faults in the relationship between the child and those who care for it in early life" (ibid). 'Emotional neglect', particularly as a result of institutional upbringing, was,

therefore, an important cause of a predisposition to psychopathy, but so too was 'over-indulgence' (ibid).

All of these writers emphasised, as did Gillespie (1930), the importance of correct child-rearing as a means of preventing delinquency and psychopathy. It is perhaps not surprising then that when, in 1966, Dr. Michael Craft wrote a paper on '*The Causation of Psychopathic Disorder*' he devoted considerable attention to alternative forms of child-rearing and, more generally, to alternative forms of social relations (Craft 1966b). Craft reviewed various theories about the relationship between genetics and personality and presented the familiar argument that although genetic traits had some *influence*, they did not *determine* personality. For Craft, 'upbringing' - and in particular parental absence - had a far more direct influence upon personality; the cases of Victor and other '*enfants sauvages*' were cited in support of this view (ibid; cf. Malson 1972). Craft also cited a study by Anna Freud of concentration camp children. Freud had argued that in comparison to London children, children who had spent their earliest years in Nazi concentration camps were "highly impulsive, self-centred, aggressive and demanding" (see Craft 1966b: 67-8). The clear implication is that these children were already presenting some of the personality traits found in psychopaths. However, "given several months of careful and sympathetic adult attention . . . they turned fairly rapidly towards the behavioural patterns expected from London children of the same age and sex . . ." (ibid); thereby, not only proving that psychopathic traits were the product of the child's early environment, but also establishing the benefits of early intervention. Craft also reviews a wide range of

research undertaken in the 1940s and 1960s on institutionalized and deprived children paying particular attention to the work of the Gluecks', published between 1950 and 1962, on the factors which lead to juvenile delinquency. The general thrust of this research was that "maternal neglect, lack of maternal affection, over-indulgence, parental mental illness, paternal disinterest, and over-affection, were all associasted with adverse personality traits in children". (ibid: 69)

Craft then went on to consider community-rearing of children in order to see whether "it is any more successful in preventing psychopathy from developing" (ibid: 70-71). Here Craft considered work such as Eaton's *Culture and Mental Disorder*, which was based upon a study of the Hutterite sect of 8,000 people in north America. The Hutterites child-rearing practices, like their social relations in general, were strict and disciplinary, but communal: each child was entitled to its "ration of love and affection, and indeed if it is asked for love, then any adult is expected to give it without demur" (Eaton, quoted in Craft 1966b: 71). Among the Hutterite's there was a virtual absence of delinquency and a complete absence of psychopathic disorder (ibid). On the other hand, Hutterite children were immature in other ways and lacked the 'independence' typical of normal American adolescents.

Craft uses this to information to move beyond his immediate concern with the affect of community patterns of child-rearing upon rates of psychopathy to suggest a more general theory about the relationship between modern culture and delinquency. He suggests that psychopathy is a side-product of the individualist and materialist ethos of modern

society. The implication is that in a more communal, less materialistic society there would be less delinquency and fewer cases of psychopathy, but that we would also lose the benefits which individualism and materialism have brought us. Hence Craft commented (on a paper by the social anthropologist Margaret Mead on community child-rearing):

> She appears to feel, perhaps even with Freud, that personality distortions, neuroses, and other community misfits, are the price one has to pay for the excessive stimulation and materialistic and educational demands of Western Civilisation, together with the dependence on exclusive mother-child relationships arising from the typical Western family. She feels that the defusion of parent-child relationships allowed by Samoan society also allows a gentler and more amiable mode of community life, which probably has fewer community misfits, but fewer strong men of action and invention. (Craft 1966b: 72)

Psychopathy as a communication problem

A more recent contribution to the quest for an explanation of psychopathy is the argument that psychopathy can be seen as a communication problem. Those who have explained psychopathy in this way have generally had the modern idea of the psychopath - as a cold, emotionless disordered personality - in mind. It has been suggested that such psychopaths live in a world of their own, with its own moral rules, values, logic, etc. and that it is therefore impossible to communicate with the psychopath from the standpoint of the dominant morality. Trying to communicate with the psychopath is therefore like trying to communicate with a person who, at the level of feelings, speaks a different language. The psychopath doesn't *appreciate* society's rules, even though he is capable of understanding them in the cognitive sense. This helps to explain why the psychopath is

seldom influenced by punishment, punishment is directed at the *immoral*, whereas the psychopath is *amoral*.

> Nor did either remonstrance or punishment make the slightest difference to him. One reformatory head, who tried to reason with him, said: 'He'd listen to you politely enough, and even make appropriate responses, but you never felt any of it was really going in. In fact, you hardly felt that you were in contact with him at all, it was as if somebody had cut the telephone wire'. (Howard Jones, quoted in Clyne 1973)

Notes

1. Frey (1948/9) is a significant exception.

2. These epidemics had an important impact upon penal policy in that they led to calls for an amendment to the definition of 'moral imbeciles' contained in the Mental Deficiency Act 1913 (see Craven 1927). The 1913 Act had defined 'moral imbeciles' as
> "persons who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no effect." (Section 1)

Since there were now several hundred children with "permanent brain damage and anti-social traits which could not be said to have existed from an early age" it was suggested that this provision be amended to allow for the confinement and treatment of these children (Walker and McCabe 1973: 211). This suggestion was accepted and in the Mental Deficiency Act, 1927 moral imbeciles were defined as persons
> ". . . in whose case there exists mental defectiveness couples with strongly vicious or criminal propensities and who require care, supervision and control for the protection of others." (Section 1)

3. For an account of psychoanalytic explanations of psychopathy see Glover (1960: 132-147).

4. We might note the similarities between this and nineteenth century theories of moral insanity; criminality is the product of a failure to develop one's moral sense.

5. This was an article in the 1937 edition of *Encyclopaedia Britannica*. Shand was also the author of *Foundations of Character* (1914).

APPENDIX 4

METHOD AND STRUCTURE OF THE THESIS

The purpose of this appendix is to explain the structure of the argument presented in the thesis. In the appendix I will try to explain why a case-study approach was adopted and why the particular examples were chosen for study. I will also present an analysis of the concept of "discourse", as it is used in the dissertation, and I will state why I find this concept useful in analysing penal thought, policy, institutions and practice.

THE CASE-STUDY APPROACH

The subject of this thesis - the shift within penal discourse from explicitly moral representations of crime and penal intervention to representations in which explicitly judgemental terms are mixed with the more subtle morality of medical language - is hardly a novel one.[1] What I try to do - which is relatively novel - is to examine, *in close detail*, the way in which medical terminology is actually used in penal discourse. Instead of aiming for a single, comprehensive explanation of the rise of psychiatric approaches to crime, I explore the complex details of medical-penal discourse. In doing so I argue that generalizations - such as 'scientific progress', 'the development of humanitarian sentiments', or 'the medicalization of social control' are inadequate for accounting for how medical concepts began to be used in penal discourse, the meanings which they carried, or the practical effects of their employment.

These purposes cannot be achieved by attempting to tell the story of medical concepts in penal discourse as a continuous narrative (structured by a few general themes) which uses specific medical concepts as illustrations. Rather, it is necessary to start at the level of the particular, looking in detail at the use of specific medical concepts. This, is seems to me, can be best achieved through a case-study approach. By focussing upon a few, key concepts and examining their use, within penal discourse, in depth, we can begin to understand both (a) the specific, unique, aspects of each concept's use (why it was adopted, what meanings it carried, what its practical effects were); and (b) the general aspects which tend to emerge again and again wherever medical concepts appear in penal discourse.

THE INEBRIATES STUDY

I came across the so-called 'medicalization of deviant drinking' while doing research for an earlier essay on nineteenth century criminological writing on drug addiction (Johnstone 1985). The concepts 'inebriety', 'dipsomania' and 'alcoholism' are interesting in this context since they raise questions concerning the 'boundaries' between morals and medicine. Getting drunk has long been condemned on ethical grounds. This condemnation was given greater force in the nineteenth century when the drinking habits of the lower classes came to be seen as an obstacle, along with other lower class recreations, to the construction of a fit and disciplined labour force and self-supporting families (Harrison 1971; ch. 2 of this thesis). Hence drinking and drunkenness clearly fall within the domain of moral and political problems. At the same time 'drunkenness' is also a

physiological state on which doctors can claim some sort of authority to speak (Conrad and Schneider 1980, ch.4). There is, however, a short gap between describing the effects of alcohol upon the body and mind and moralising about drinking alcohol, a gap which nineteenth century doctors found fairly easy to cross back and forth. For these reasons, these concepts seemed to me to be rich in their potential for a study of the use of medical concepts in penal discourse.

A little more investigation revealed that the problem of 'habitual drunkards' or 'inebriates' was a central one for penal reformers in the second half of the nineteenth century. The 'inebriate' was the subject of a number of official inquiries, a multitude of articles, and a specialist journal. In addition, specialist institutions were constructed for the punishment and reformation of inebriates (see ch.3). This level of concern is interesting in itself, given that most 'habitual drunkards' were petty offenders, who generally received short sentences of imprisonment. Why such an apparently 'unworthy' group should be regarded as constituting such a important problem by 'men of science' itself seemed interesting.

This concern with inebriates emerged alongside the problem of drunkenness and intemperance in general. Surprisingly, there was very little contact between the two concerns. This alerted me to the fact that the concern of penal reformers with inebriates (a specific social group) was rather different to, and more specific than, the more general concern with intemperance among the population in general (see ch.2). There seemed, therefore, to be a very specific problem requiring explanation: i.e. how inebriates came to be constituted as a specific category, requiring specific investigation and specialist

institutions, and how they (and their 'treatment') were conceived and represented.

The fact that institutions were constructed for the treatment of inebriates also allowed me to develop another central theme of the study. A central idea behind the study was that in order to understand the impact of psychiatric ideas upon criminal justice it is necessary to concentrate not just upon ideas about criminals and the causes of crime, but also upon ideas about penal intervention and institutions. It seemed to me that psychiatric thinking on penal intervention had at least as much impact upon criminal justice as had psychiatric thinking about crime. The discourse on inebriates and habitual drunkards turned out, in fact, to be as much if not more concerned with questions of penal and reformative practices and the nature of penal institutions, than with the nature of inebriety and alcoholism.

MORAL INSANITY, MORAL IMBECILITY AND PSYCHOPATHY

This second case study started out as a study of how the concept of 'psychopathy' was used in penal discourse. Here I will explain why I saw the concept of psychopathy as important, and then state why I extended the study to include 'moral insanity' and 'moral imbecility'.

The concept of psychopathy is central to relations between criminal justice and psychiatry (and more generally between morals and medicine). It seems to denote, *simultaneously*, ideas of madness and badness. The term is generally used to denote behaviour which is so persistently erratic that it can be read as a sign of madness, irrespective of the fact that other signs of madness are absent. The term can be placed, therefore, exactly on the boundaries between

morals and medicine (a fact which helps to explain the controversy which has always surrounded the concept and the excitement which the topic of psychopathy raises). This is even more evident in the case of '*moral insanity*', a precursor of psychopathy, which makes clear reference to both the language of ethics and the language of psychiatry. This status of 'psychopathy' - at the boundaries of morals and medicine (and, I might add, at the boundaries of lay and scientific understandings of crime) - made it ideal for studying the interpenetration of the legal and the psychiatric.

The concepts of 'moral insanity' and 'moral imbecility' can be regarded as precursors of 'psychopathy' since, not only are the concepts closely related in their meaning, but also, there is a clear historical link between the concepts (see ch.6). It seemed a logical step, therefore, to extend the study of 'psychopathy' backwards, to look at the use of the concepts of moral insanity and moral imbecility in penal discourse. This proved interesting in itself, and also allowed a greater understanding of 'psychopathy', since many of the issues raised by the use of the concept of 'psychopathy' had been raised more sharply in relation to 'moral insanity'.

Extending the study to include 'moral insanity' and 'moral imbecility' was useful in another way; it allowed me to explore the issue of how medical concepts came to be introduced into penal discourse. By studying a series of concepts, I could look at the reasons for one concept being rejected and another being adopted. This led, in particular, to the development of two related themes. First, that medical concepts tend to be introduced into penal discourse as much for their persuasive value as for their explanatory value.

Secondly, that medical terminology is often superimposed upon administrative categories; classifications which are made for non-medical reasons, are often *represented* as classifications founded upon medical knowledge.

STUDYING IDEAS THROUGH READING DISCOURSE

In order to explain why I used the term 'discourse' in the dissertation, and what I mean by it, it is necessary to reflect, more generally, upon the nature of the study.

At its most general the thesis can be regarded as a contribution to the history of ideas. More specifically, it can be seen as a history of psychiatric ideas about delinquency, delinquents, penal intervention and penal institutions. However, the study differs from conventional histories of ideas in a number of respects. In the context of this discussion, the most important difference concerns the type of idea which the thesis examines.

The thesis does not focus upon the lofty philosophical ideas, or the leading psychiatric and criminological theories of the day. Rather, its focus is upon more 'humble' ideas concerning the management and control of delinquents and of groups of persons who are are at risk of becoming delinquent. These ideas are the product, not so much of theoretical reasoning by 'thinkers' (whose concern might be to produce definitive theories of crime and punishment), but of practical reasoning by practitioners, whose concern is to understand how delinquents can be better managed and reformed. Hence, the ideas on delinquency which I look at are not so much ideas about the essential nature of delinquency, but about the habits and background of

delinquents and about how delinquents can be disciplined and 'moralized'. These are ideas which are useful in deciding how delinquents can best be dealt with. And the ideas on penal intervention which I look at are not so much 'big' ideas about the right to punish, rather they are practical ideas about the best way to punish (or treat) various types of delinquent, about how punishment can be used more effectively so that it acts as a moralizing, rather than a brutalizing, force, about how penal institutions can be reformed so that they can be more efficient and effective, and its deleterious effects reduced. What I am concerned with then is practitioner's understandings of their professional tasks. I am concerned with practitioner's understandings of what they, and their colleagues, are doing and are trying to do. I am concerned with the ideas which inform penal practice and - since it is difficult to see how practices can be described without reference to practitioner's accounts of what they are doing - with the ideas which constitute penal practice. A study of these ideas, I would argue, can reveal as much (if not more) about the underlying 'rationality' of the penal system, than would an examination of more lofty ideas on crime an punishment.

The next question is that of how we can reconstruct these ideas. How do we account for practitioner's self-understandings of their professional tasks. One possible approach might be a psychological one; we might use psychological techniques in order to understand the thought patterns of psychiatrists. A more simple and, I would argue, a more useful approach is to simply analyse the 'writing' of these practitioners. Practitioners express their views in a number of

settings: including evidence before inquiries, reports, short articles in 'practitioner's journals (such as the Howard Journal) and books. This writing provides the most direct access to the way psychiatrists understand their professional tasks (no doubt this could be supplemented by other methods). I use the term 'discourse' to refer to these communications between practitioners and from practitioners to others (such as politicians, administrators, and the public). The analysis of 'penal discourse' then is an analysis of the underlying rationality of the penal system *through* a study of the words which practitioners use to explain, describe and justify their professional tasks.

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